Welcome

WELCOME TO THE PAE AND TPAES SYSTEM ONLINE TRAINING.

THIS TRAINING IS FOR ALL TPAES USERS, QUALIFIED ASSESSORS, AND STAFF WHO COMPLETE AND/OR ASSIST WITH A PAE.

TN Division of TennCare

Video Tutorials and Cheat Sheets

Throughout this presentation, you will be able to view video tutorials that will walk you through the PAE submission process. Click on this picture to watch the video. It will redirect you to the video but will not close this training.

In addition, there are cheat sheets linked on the right side of the slide that will assist with the technical aspect of the submission process within TPAES. Click on the links to review and print the cheat sheets related to that video.

Who am I?

- MCO
- AAAD
- Nursing Facility
- Hospital
- Long Term Services and Supports
- TennCare Member Services
- Ascend

Managed Care Organizations

A **Managed Care Organization (MCO)** is assigned when a person becomes Medicaid eligible. The MCO is responsible for submitting NF & HCBS PAEs for Medicaid eligible individuals. The MCO may also submit PASRRs.

MCOs also contract and collaborate with nursing facilities for CHOICES members who are in a nursing home or might go to a nursing home. MCOs are also responsible for the coordination of medical, behavioral, and long term care services. MCOs are responsible for CHOICES disenrollment functions and group transitions (including working with the NF on a discharge plan to transition a CHOICES member to the community when possible).

Amerigroup RealSolutions in healthcare™

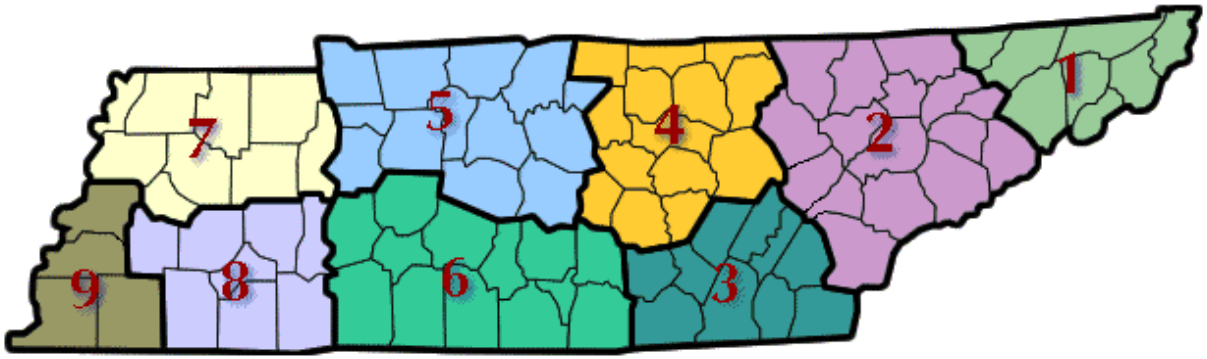
UnitedHealthcare Community Plan

Local SOLUTIONS, Meaningful RESULTS

BlueCare Tennessee

The Area Agencies on Aging and Disability

The Area Agencies on Aging and Disability (AAAD) are the single point of entry into the CHOICES program. The AAAD may submit NF and HCBS PAEs and may assist in the submission of a Medicaid financial eligibility application. The AAADs may also submit PASRRs.



Nursing Facilities

Nursing facilities (NF) work with patients to deliver the care they need. They may submit NF PAEs to TennCare and PASRRs to Ascend for review. NFs should work and communicate with the MCO about each CHOICES member, especially when a transition or discharge is occurring.

Hospital

Hospitals may submit PASRRs on behalf of patients seeking nursing facility placement as a PASRR must be completed prior to admission into a Medicaid or Medicare certified NF. Hospitals may also submit NF PAEs.

Long-Term Services and Supports

Long Term Services and Supports (LTSS) receives PASRR information (via Ascend's web based screening system), handles medical level of care determinations (via the PAE application), and verifies that enrollment criteria has been met, including assuring that transitions submitted by the MCO are appropriate. LTSS also handles PAE and enrollment appeals. For questions about PAEs, LTSS enrollment or appeals, the LTSS Help Desk can be reached at 1-877-224-0219.

LTSS does not handle financial eligibility determinations.

TennCare Member Services

TennCare Member Services handles all financial eligibility determinations, to include working an applicant's Medicaid application. They also calculate a person's patient liability and process item D deductions. If you have financial eligibility questions please call TennCare Connect at 1-855-259-0701.

Ascend

Ascend, a MAXIMUS Company, is the state's PASRR vendor that handles all Level I screens and subsequent Level II comprehensive reviews, if necessary. If you have PASRR questions please contact the Ascend Help Desk at Ascend-TNPASRR@maximus.com

Navigating TPAES

TPAES

Now that you know what your role is, you may need access to TPAES.

- TennCare's PAE Tracking System (TPAES) is the software system that houses all PAEs submitted by NFs, hospitals, MCOs, or AAADs.

How do I get access to TPAES?

First, you must determine who within your organization will submit PAEs. Those submitters will complete the following:

- Complete the Online training in it's entirety (the certificate of completion will automatically be sent to TennCare once submitted, upon completion of the training)
- Sign the Acceptable Use Policy (AUP), found here (must be submitted as a PDF)
- A TennCare Medicaid Management Information System (TCMIS) Access Request form (please reach out to our Help Desk at the email below for the most up to date form)

Second, once completed, all forms must be submitted to LTC.Operations@tn.gov. An LTSS employee will process the request and get back to you within 10 business days.

Rules

- References to Rules stated within this training may be found on the TennCare website here.
- For further research, LTSS updates our LTSS Partners site with the most up to date reference materials here or you can call our Help Desk at 1-877-224-0219.

For updated forms please click on LTSS Forms under Partners-Program Updates on the LTSS Homepage or click here.

Now that you've gained access and have read TennCare Rules, where do you start?

Without an appropriate PASRR a person may not reside in a nursing facility.

The next few slides will cover:

- What a PASRR is
- How to submit a PASRR
- PASRR Resources

PASRR

What is a PASRR?

A PASRR is a **Pre-Admission Screening and Resident Review** completed for all persons admitting into a Medicaid certified nursing facility, regardless of payer source. This screen is submitted for persons with known or suspected mental illness, intellectual disability, related condition or developmental delay.

This means that the patient may never need a PAE because Medicaid is not the payer source but he/she *still must have a PASRR*. A PASRR level I screen is used to determine whether an individual is suspected of having a mental illness, intellectual disability, related condition or developmental delay and, if so, a level II evaluation must be completed. A level II review is completed by a TennCare contractor and will determine whether the individual is appropriate for nursing facility placement and if the individual requires specialized services.

To learn more and see the most updated TennCare Rule in its entirety please click here.

When should I submit a PASRR?

A PASRR is required prior to a patient entering a certified Medicaid nursing facility. A NF may not receive Medicaid reimbursement for a patient until a PASRR has been completed and the person is determined appropriate for nursing facility placement.

*This is a federal requirement

Who needs a PASRR?

- Any person admitting into a Medicaid certified NF must have a PASRR regardless of payer source.
- Persons in CHOICES Group 2 or 3 are NOT required to complete the PASRR process unless they are admitted to a NF for a short term stay.

How to Submit a PASRR

- **Tennessee transitioned its Preadmission Screening and Resident Review (PASRR) program to a new Level I submission process on December 1, 2016.**

- Ascend is the state's PASRR vendor, and processes Level I screens and subsequent Level II comprehensive reviews, if necessary.

- Providers no longer utilize TPAES when submitting a PASRR. Providers now utilize Ascend's web based screening system: https://www.ascendami.com/ami/Home.aspx

Ascends' Review

- For individuals in PASRR population, the Level of Care (LOC) will be part of the PASRR decision made by Ascend.

PASRR Resources

- Ascend's website has various training material on how to submit a PASRR.
- System User Guides, Webinars, and Newsletters are all available to assist submitters.
- **To view Ascend's PASRR training materials click here:** https://www.ascendami.com/ami/Providers/YourState/TennesseePASRRUserTools.aspx

What is a PAE?

THE PRE-ADMISSION EVALUATION (PAE) APPLICATION DETERMINES AN INDIVIDUAL'S MEDICAL ELIGIBILITY (LEVEL OF CARE) FOR MEDICAID-REIMBURSED LONG-TERM SERVICES AND SUPPORTS.

ALSO USED FOR DETERMINING AN INDIVIDUAL'S COST NEUTRALITY CAP

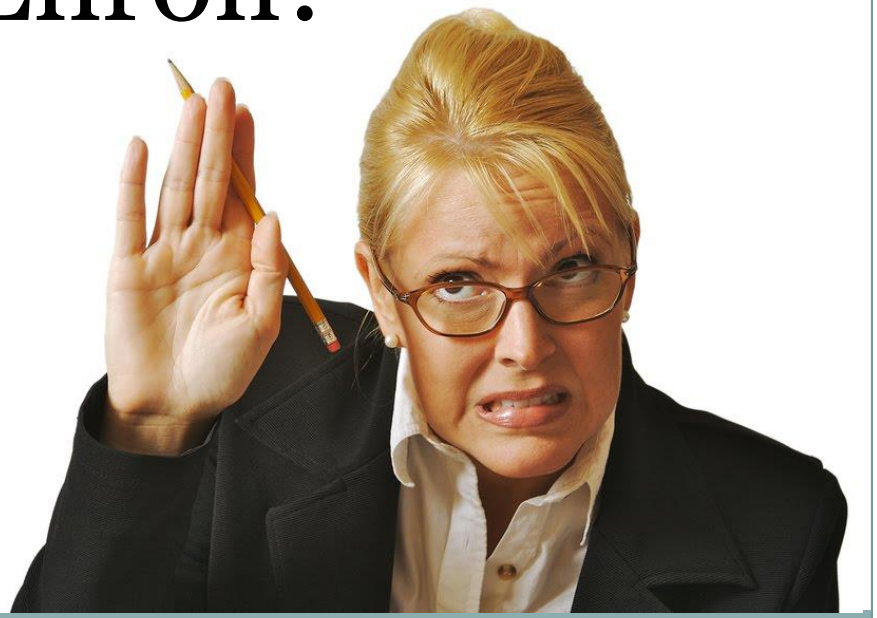
FULL DEFINITION - RULE 1200-13-01.02:

CHOICES Groups 1, 2, & 3

Who qualifies?

What Documents are Required?

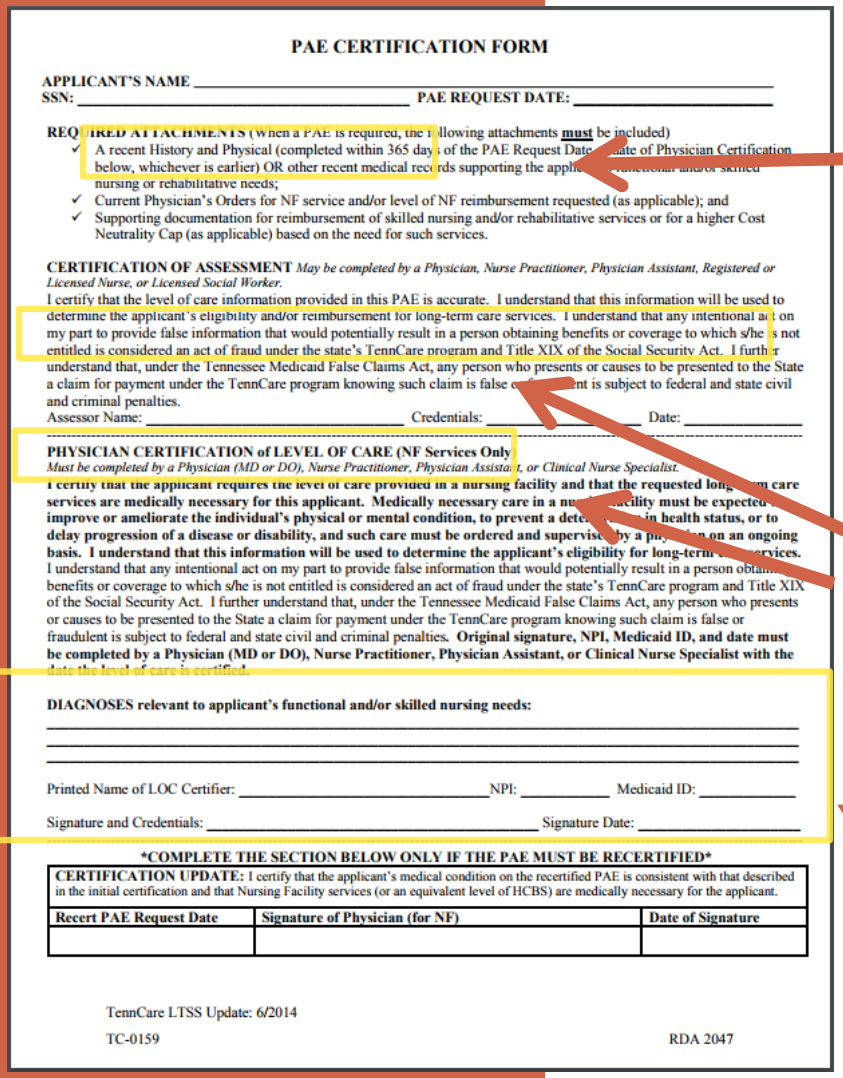
How to Enroll?



CHOICES Group 1
Who qualifies?

- ✓ Enrolled in Medicaid
- ✓ All ages
- ✓ Meet nursing facility level of care criteria
- ✓ Must have current Physician's Order for NF Services

CHOICES Group 1 Documentation Requirements



PAE CERTIFICATION FORM

APPLICANT'S NAME _____
SSN: _____ **PAE REQUEST DATE:** _____

REQUIRED ATTACHMENTS (When a PAE is required, the following attachments **must** be included)
- ✓ A recent History and Physical (completed within 365 days of the PAE Request Date or date of Physician Certification below, whichever is earlier) OR other recent medical records supporting the applicant's functional and/or skilled nursing or rehabilitative needs;
- ✓ Current Physician's Orders for NF service and/or level of NF reimbursement requested (as applicable); and
- ✓ Supporting documentation for reimbursement of skilled nursing and/or rehabilitative services or for a higher Cost Neutrality Cap (as applicable) based on the need for such services.

CERTIFICATION OF ASSESSMENT *May be completed by a Physician, Nurse Practitioner, Physician Assistant, Registered or Licensed Nurse, or Licensed Social Worker.*
I certify that the level of care information provided in this PAE is accurate. I understand that this information will be used to determine the applicant's eligibility and/or reimbursement for long-term care services. I understand that any intentional act on my part to provide false information that would potentially result in a person obtaining benefits or coverage to which s/he is not entitled is considered an act of fraud under the state's TennCare program and Title XIX of the Social Security Act. I further understand that, under the Tennessee Medicaid False Claims Act, any person who presents or causes to be presented to the State a claim for payment under the TennCare program knowing such claim is false or fraudulent is subject to federal and state civil and criminal penalties.
Assessor Name: _____ Credentials: _____ Date: _____

PHYSICIAN CERTIFICATION of LEVEL OF CARE (NF Services Only
Must be completed by a Physician (MD or DO), Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist.
I certify that the applicant requires the level of care provided in a nursing facility and that the requested long-term care services are medically necessary for this applicant. Medically necessary care in a nursing facility must be expected to improve or ameliorate the individual's physical or mental condition, to prevent a deterioration in health status, or to delay progression of a disease or disability, and such care must be ordered and supervised by a physician on an ongoing basis. I understand that this information will be used to determine the applicant's eligibility for long-term care services. I understand that any intentional act on my part to provide false information that would potentially result in a person obtaining benefits or coverage to which s/he is not entitled is considered an act of fraud under the state's TennCare program and Title XIX of the Social Security Act. I further understand that, under the Tennessee Medicaid False Claims Act, any person who presents or causes to be presented to the State a claim for payment under the TennCare program knowing such claim is false or fraudulent is subject to federal and state civil and criminal penalties. **Original signature, NPI, Medicaid ID, and date must be completed by a Physician (MD or DO), Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist with the** date the level of care is certified.

DIAGNOSES relevant to applicant's functional and/or skilled nursing needs:
_____
_____
_____

Printed Name of LOC Certifier: _____ NPI: _____ Medicaid ID: _____

Signature and Credentials: _____ Signature Date: _____

COMPLETE THE SECTION BELOW ONLY IF THE PAE MUST BE RECERTIFIED

CERTIFICATION UPDATE: I certify that the applicant's medical condition on the recertified PAE is consistent with that described in the initial certification and that Nursing Facility services (or an equivalent level of HCBS) are medically necessary for the applicant.

Recert PAE Request Date	Signature of Physician (for NF)	Date of Signature

TennCare LTSS Update: 6/2014
TC-0159 RDA 2047

- ✓ A recent medical history and physical (completed within 365 days of the PAE Submit Date) or current medical records supporting the need for care
- ✓ Supporting documentation for reimbursement of skilled nursing and/or rehabilitative services based on the need for such services
- ✓ Freedom of CHOICE Form
- ✓ Certification of Assessment
- ✓ Physician Certification of Level of Care
- ✓ Diagnoses relevant to applicant's functional and/or skilled nursing needs
- ✓ An *original* signature by a physician, NP, PA or CNS and credentials, NPI, Medicaid ID, date, and printed name must be completed on the form. If it is incomplete, you may receive a technical denial.

Click here to see the PAE Certification Form

CHOICES Group 1
Enrollment

Enrollment into Group 1 may not occur until the following criteria are met:

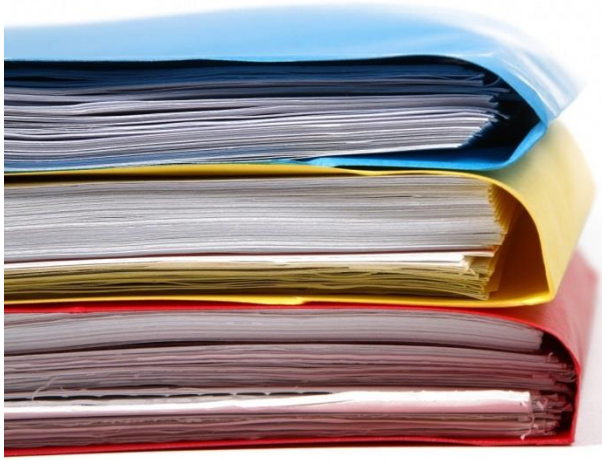
- An appropriate PASRR deeming the applicant appropriate for nursing facility
- An approved PAE/LOC for nursing facility level of care
- Medicaid eligibility (determined by TennCare Member Services)
- Freedom of CHOICE Form
- Medicaid Only Payer Date or
- Admission Date entered into Path Tracker

CHOICES Group 2
Who qualifies?

- ✓ Meet nursing facility level of care criteria
- ✓ Qualify for TennCare
  - ✓ - SSI recipients OR
  - ✓ - In an institutional category
- ✓ Need Home and Community Based Services (HCBS) as an alternative to nursing facility care and on an ongoing basis.

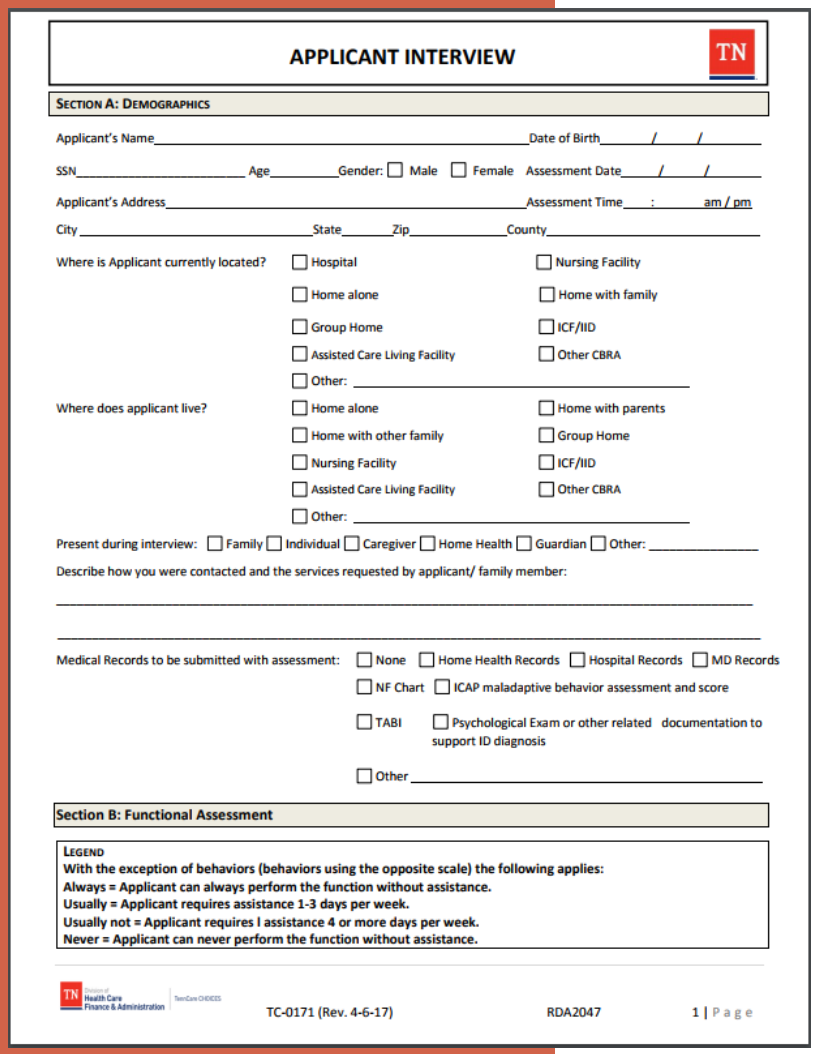
*The Bureau has the discretion to apply an Enrollment Target to this group.

CHOICES Group 2 Documentation Requirements



- A History and Physical OR other medical records supporting the applicant's functional and/or skilled nursing or rehabilitative needs completed within 365 days of the PAE Submit Date

CHOICES Group 2 Documentation Requirements



APPLICANT INTERVIEW

SECTION A: DEMOGRAPHICS

Applicant's Name_____ Date of Birth____/____/____

SSN_____ Age_____ Gender: ☐ Male ☐ Female Assessment Date____/____/____

Applicant's Address_____ Assessment Time____:____ am / pm

City_____ State_____ Zip_____ County_____

Where is Applicant currently located?
☐ Hospital ☐ Nursing Facility
☐ Home alone ☐ Home with family
☐ Group Home ☐ ICF/IID
☐ Assisted Care Living Facility ☐ Other CBRA
☐ Other: _____

Where does applicant live?
☐ Home alone ☐ Home with parents
☐ Home with other family ☐ Group Home
☐ Nursing Facility ☐ ICF/IID
☐ Assisted Care Living Facility ☐ Other CBRA
☐ Other: _____

Present during interview: ☐ Family ☐ Individual ☐ Caregiver ☐ Home Health ☐ Guardian ☐ Other: _____

Describe how you were contacted and the services requested by applicant/ family member:

_____

_____

Medical Records to be submitted with assessment: ☐ None ☐ Home Health Records ☐ Hospital Records ☐ MD Records
☐ NF Chart ☐ ICAP maladaptive behavior assessment and score
☐ TABI ☐ Psychological Exam or other related documentation to support ID diagnosis
☐ Other _____

Section B: Functional Assessment

LEGEND
With the exception of behaviors (behaviors using the opposite scale) the following applies:
Always = Applicant can always perform the function without assistance.
Usually = Applicant requires assistance 1-3 days per week.
Usually not = Applicant requires l assistance 4 or more days per week.
Never = Applicant can never perform the function without assistance.

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- ✓ HCBS documentation tools
  - ✓ Applicant Tool
  - ✓ Collateral Tool

The Applicant and Collateral tools are **optional** for completion and submission when you are unable to obtain the documentation needed to support the diagnosis as provided by the physician and the deficits indicated on the PAE.

Certifying the HCBS Tools

- If an HCBS PAE is denied (not accepted) by TennCare and you subsequently submit a new PAE, you may use the previous HCBS documentation tools in the new PAE as long as the following is true;
  - The applicant was seen face to face to verify in person that there has been no change in their condition from the date of the originally completed tool;
  - The assessment tool was reviewed with the applicant or collateral interviewee and they agree there has been no change in the applicant's condition from the originally completed tool; and
  - The previous assessment is less than 365 days old.

- If all of the above are true, you may print and sign your name, add your credentials, date and Assessor code to the document. By providing this information and submitting to TennCare you are certifying the accuracy of the document.

CHOICES Group 2
Enrollment

Enrollment into Group 2 may not occur until the following criteria are met:

- ✓ An approved unexpired PAE for nursing facility level of care
- ✓ Medicaid eligibility (determined by TennCare Member Services)
- ✓ Group 2 must have capacity within the enrollment target
- ✓ Person's needs must be safely met in the community and within the cost neutrality cap

CHOICES Group 3
Who qualifies?

- ✓ Individuals age sixty-five (65) and older
- ✓ Adults age twenty-one (21) and older with physical disabilities
- ✓ Does not meet the nursing facility level of care, but are "At Risk for Institutionalization," as defined by the State.
- ✓ Qualify for TennCare
  - Only SSI (Supplemental Security Income from the Social Security Administration) recipients

*The Bureau has the discretion to apply an Enrollment Target to this group. There is not currently a cap on the Group 3 enrollment target

CHOICES Group 3
Enrollment

Enrollment into Group 3 may not occur until the following criteria are met:

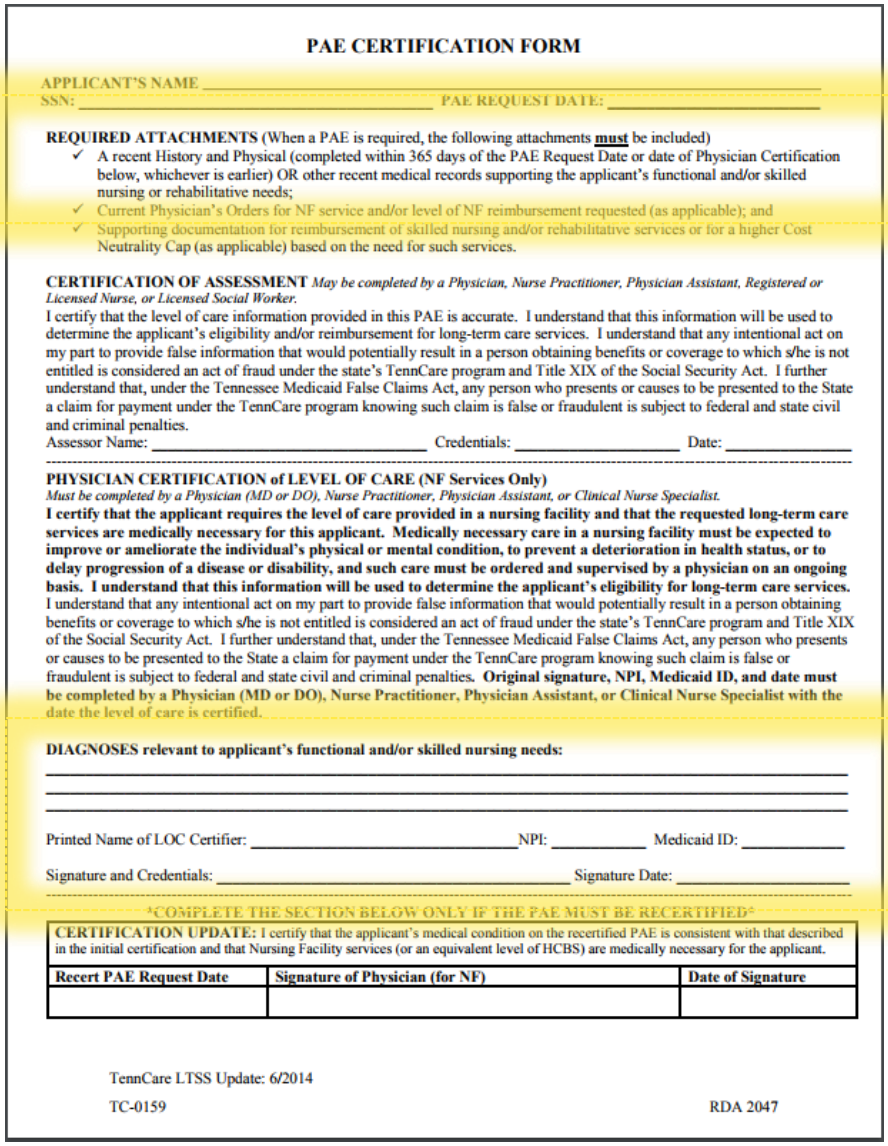
- ✓ An approved unexpired PAE for At Risk level of care
- ✓ SSI Recipient
- ✓ Must be in the target population (age 65 and older or adults age 21 and older with a chronic physical disability)
- ✓ Person's needs must be safely met in the community

Certification

When certifying a PAE this verifies that the applicant requires the level of care provided in a nursing facility or an HCBS setting and that the requested long-term care services are medically necessary for this applicant. Please be aware that this information will be used to determine the applicant's eligibility for long-term care services.

*Please note, a physician's signature is not required on the certification form for an HCBS PAE. The certifier of accuracy portion of the certification tab in TPAES must still be completed.

Certification Attachment Required- this form is required for Group 1 PAEs



PAE CERTIFICATION FORM

APPLICANT'S NAME _____
SSN: _____ PAE REQUEST DATE: _____

REQUIRED ATTACHMENTS (When a PAE is required, the following attachments **must** be included)

- ✓ A recent History and Physical (completed within 365 days of the PAE Request Date or date of Physician Certification below, whichever is earlier) OR other recent medical records supporting the applicant's functional and/or skilled nursing or rehabilitative needs;
- ✓ Current Physician's Orders for NF service and/or level of NF reimbursement requested (as applicable); and
- ✓ Supporting documentation for reimbursement of skilled nursing and/or rehabilitative services or for a higher Cost Neutrality Cap (as applicable) based on the need for such services.

CERTIFICATION OF ASSESSMENT *May be completed by a Physician, Nurse Practitioner, Physician Assistant, Registered or Licensed Nurse, or Licensed Social Worker.*

I certify that the level of care information provided in this PAE is accurate. I understand that this information will be used to determine the applicant's eligibility and/or reimbursement for long-term care services. I understand that any intentional act on my part to provide false information that would potentially result in a person obtaining benefits or coverage to which s/he is not entitled is considered an act of fraud under the state's TennCare program and Title XIX of the Social Security Act. I further understand that, under the Tennessee Medicaid False Claims Act, any person who presents or causes to be presented to the State a claim for payment under the TennCare program knowing such claim is false or fraudulent is subject to federal and state civil and criminal penalties.

Assessor Name: _____ Credentials: _____ Date: _____

PHYSICIAN CERTIFICATION of LEVEL OF CARE (NF Services Only)

Must be completed by a Physician (MD or DO), Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist.

I certify that the applicant requires the level of care provided in a nursing facility and that the requested long-term care services are medically necessary for this applicant. Medically necessary care in a nursing facility must be expected to improve or ameliorate the individual's physical or mental condition, to prevent a deterioration in health status, or to delay progression of a disease or disability, and such care must be ordered and supervised by a physician on an ongoing basis. I understand that this information will be used to determine the applicant's eligibility for long-term care services. I understand that any intentional act on my part to provide false information that would potentially result in a person obtaining benefits or coverage to which s/he is not entitled is considered an act of fraud under the state's TennCare program and Title XIX of the Social Security Act. I further understand that, under the Tennessee Medicaid False Claims Act, any person who presents or causes to be presented to the State a claim for payment under the TennCare program knowing such claim is false or fraudulent is subject to federal and state civil and criminal penalties. **Original signature, NPI, Medicaid ID, and date must be completed by a Physician (MD or DO), Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist with the date the level of care is certified.**

DIAGNOSES relevant to applicant's functional and/or skilled nursing needs:

_____
_____
_____

Printed Name of LOC Certifier: _____ NPI: _____ Medicaid ID: _____

Signature and Credentials: _____ Signature Date: _____

COMPLETE THE SECTION BELOW ONLY IF THE PAE MUST BE RECERTIFIED

CERTIFICATION UPDATE: I certify that the applicant's medical condition on the recertified PAE is consistent with that described in the initial certification and that Nursing Facility services (or an equivalent level of HCBS) are medically necessary for the applicant.

Recert PAE Request Date	Signature of Physician (for NF)	Date of Signature

TennCare LTSS Update: 6/2014
TC-0159 RDA 2047

Applicant's Name and Applicant's SSN.

Diagnoses relevant to applicant's functional and/or skilled nursing needs.

An *original* physician, NP, PA or CNS signature and credentials, NPI, Medicaid ID, date, and printed name must be filled out when completing a NF PAE and must match the TPAES certification tab.

PAE Log-in & Homepage

Cheat Sheets

PAE Log-in & Homepage

Demographic Section – NF PAE

Cheat Sheets

Demographic Section-NF PAE

Demographic Section – HCBS PAE

Cheat Sheets

Demographic Section-HCBS PAE

TN Division of TennCare | LTSS

Level of Care

Meeting Level of Care (Groups 1, 2 and 3)

- NF LOC (Group 1 and 2)-
  - Have a total acuity score of at least 9 on the TennCare NF LOC Acuity Scale; or
  - Meet At Risk LOC and be determined by TennCare to not qualify for enrollment in CHOICES Group 3 because needs cannot be safely met.

- At Risk LOC (Group 3)-
  - Have at least one significant functional deficit on the TennCare NF LOC Acuity Scale and be determined by TennCare that needs can be safely met in the community

Determining Level of Care

Determining Level of Care

- LOC determinations include an assessment of certain functional needs-the need for assistance with Activities of Daily Living (ADLs) and an assessment of certain clinical needs.
- ADLs consist of self care tasks that enable a person to live independently in his own home such as:
  - Transferring from the bed to a chair
  - Walking or using a wheelchair
  - Eating
  - Toileting
- LOC determinations also include considerations of other factors that impact a person's ability to live safely and independently in the community
  - Communication
  - Cognitive Status
  - Behavior
  - Taking medicine

Determining Level of Care

NF LOC Acuity Scale

- TennCare reviews each functional and clinical need and assigns a weighted value of each component on a scale of 0 to a maximum of 5, depending on the amount of assistance needed.
- Medical eligibility is based on each applicant's cumulative score, which reflects the acuity of that person's needs.
- This approach:
  - Recognizes that not all functional and clinical needs are alike;
  - Takes into consideration those types of needs that may require more assistance; and
  - Provides some consideration for lesser levels of need for assistance (for a person who needs help only *some* of the time)

Level of Care

Acuity Scale

The acuity scale applies weighted values to the answer that you provide to each question on the functional assessment:

ADL (or related) Deficiencies		Weights					
Functional Measure	Condition	Always	Usually	Usually Not	Never	Max Individual Score	Max Acuity Score
Transfer	Highest value of two measures	0	1	3	4	4	4
Mobility		0	1	2	3	3	
Eating		0	1	3	4	4	4
Toileting	Highest value of three possible questions for the toileting measure	0	0	1	2	2	3
Incontinence care		0	1	2	3	3	
Catheter/ostomy care		0	1	2	3	3	
Orientation		0	1	3	4	4	4
Expressive communication	Highest value of two possible questions for the communication measure	0	0	0	1	1	1
Receptive communication		0	0	0	1	1	
Self-administration of medication	First question only (excludes SS Insulin)	0	0	1	2	2	2
Behavior		3	2	1	0	3	3
Maximum Possible ADL (or related) Acuity Score							21

Level of Care

Skilled Services/Enhanced Respiratory Care

Utilizing the answers that are provided on the PAE submission:

Skilled Services	Associated Points
Ventilator (does not include vent weaning services)	5
Infrequent Tracheal Suctioning (Previously named: New Tracheostomy or Old Tracheostomy: Requiring Suctioning Through The Tracheostomy Multiple Times Per Day At Less Frequent Intervals, i.e. < every 4 hours)	3
Total Parenteral Nutrition TPN	3
Complex wound care (e.g., infected wounds, dehisced wounds, 3 or more stages and/or stage 4 wounds, unstageable wounds and deep tissue injury (as defined by NPUAP-National Pressure Ulcer Advisory Panel)	3
Wound care for stage 3 or 4 decubitus	2
Peritoneal Dialysis	2
Tube feeding, enteral	2
Intravenous Fluid Administration	1
Injections, sliding scale insulin	1
Injections, other IV,IM	1
Isolation Precautions	1
PCA Pump	1
Occupational therapy by OT or OT assistant	1
Physical therapy by PT or PT assistant	1
Teaching catheter/ ostomy care	0
Teaching self-injection	0
Enhance Respiratory Care Service	**Associated Points**
Chronic Ventilator	5
Secretion Management Tracheal Suctioning	4
Maximum Possible Skilled Services/Enhance Respiratory Care Acuity Score	**5**

= total of all actual maximum acuity scores; only up to 5

Level of Care

Acuity Scale

Maximum Possible ADL (or related) Acuity Score		Actual Score
Maximum Possible Skilled Services Acuity Score	+	Actual Score
	=	
Maximum Total NF LOC Acuity Score		26

All answers may be approved or denied by TennCare based on supporting documentation. If an answer is denied, the assigned value would not apply to the "actual score". Only those approved will apply to the "actual score". This means the total acuity score may change once a PAE is reviewed by TennCare.

Safety Determination

*Safety Determinations can occur on the front end of the PAE Submission process

What is a Safety Determination?

Rule:
A decision made by the Bureau in accordance with the process and requirements described in Rule 1200-13-01-.05(6) regarding whether an Applicant would qualify to enroll in CHOICES Group 3 (including Interim CHOICES Group 3) or if there is sufficient evidence, as required and determined by TennCare, to demonstrate that the necessary intervention and supervision needed by the Applicant cannot be safely provided within the array of services and supports that would be available if the Applicant was enrolled in CHOICES Group 3, including CHOICES HCBS up to the Expenditure Cap of $15,000, non-CHOICES HCBS available through TennCare (e.g., home health), cost-effective alternative services (as applicable), services available through Medicare, private insurance or other funding sources, and natural supports provided by family members or other caregivers who are willing and able to provide such care, and which may impact the Applicant's NF LOC eligibility (see Rule 1200-13-01-.1-(4)(b)2.(i)(II) and 1200-13-01-.10(4)(b)2.(ii)(II)).

What does that mean?

- If the applicant cannot be safely served in CHOICES Group 3 within the expenditure cap, using natural supports and all other services available, a Safety Determination Request may be submitted to TennCare with the PAE application.
- The submitter must *show* TennCare why the person would be unsafe if enrolled in CHOICES Group 3.

Safety Determination Request

- If the applicant requests a Safety Determination Request but the PAE assessor does not agree, the assessor must still complete the Safety Determination Request Form and request the safety review in TPAES.

- This should be indicated on the form by selecting *"This Safety Determination Request Form was completed at the request of the applicant/representative"*.

Safety Determination Request

WHEN SHOULD A SAFETY DETERMINATION REVIEW BE REQUESTED?

Keep in mind….

To meet NF LOC the applicant must have a TennCare approved score of 9 or above on the acuity scale or TennCare must determine the person's needs cannot be safely met in the community with the array of services and supports that would be available if the applicant was enrolled in the CHOICES Group 3.

When to request a safety determination

- When the applicant's acuity score is below a 9 but meets At Risk LOC (one significant deficit) on the functional assessment and it appears their needs can't be safely met within the array of services and supports if enrolled in Group 3.

What if the applicant scores a 9 or above?

- The PAE assessor must ensure that all documentation to approve that score of 9 or above is included with the PAE.
- TennCare would not expect a Safety Determination Request for PAEs scored 9 or above.

Safety Review

How does Tenncare review for safety?

Review of Information

Each safety determination shall include review of information submitted to TennCare as part of the Safety Determination request, including, but not limited to:

1. Diagnosed complex acute or chronic medical conditions which require frequent, ongoing skilled and/or rehabilitative interventions and treatment by licensed professional staff;
2. A pattern of recent falls resulting in injury or with significant potential for injury;
3. An established pattern of recent emergent hospital admissions or emergency department utilization for emergent conditions;
4. Recent nursing facility admissions, including precipitating factors and length of stay;
5. An established pattern of self-neglect that increases risk to personal health, safety and/or welfare requiring involvement by law enforcement or Adult Protective Services;
6. A determination by a community-based residential alternative provider that the Applicant's needs can no longer be safely met in a community setting; and
7. The need for and availability of regular, reliable natural supports, including changes in the physical or behavioral health or functional status of family or unpaid caregivers.

Benefits

In addition to all required documentation the PAE assessor must know and understand all of the Group 3 and TennCare benefits to determine whether the applicant can be safely served in Group 3.

- Members enrolled in Group 3 not only receive Group 3 benefits, they are also eligible to receive TennCare benefits (non CHOICES HCBS), including home health services. TennCare benefits, and CHOICES minor home modifications do not count against the Group 3 expenditure cap.

- Cost-Effective alternatives (CEA) may also be utilized to safely serve a member in the community. CEAs are approved at the MCO's discretion.

Group 3 Benefits

The total cost of these kinds of care can't be more than $15,000 per calendar year, not counting home modifications.

- Adult Day Care: Up to 2,080 hours per calendar year, a place that provides supervised care and activities during the day
- Assistive Technology: Up to $900 per calendar year, certain low-cost items or devices that help the member do things easier or safer in their home like grabbers to reach things
- Attendant Care: Up to 1,080 hours per calendar year
- Personal Care Visits: Up to 2 visits per day, lasting no more than 4 hours per visit; there must be at least 4 hours between each visit
- Home-Delivered Meals: Up to 1 meal per day
- In-Home Respite Care: Up to 216 hours per calendar year, someone to come and stay with the member in their home for a short time so their caregiver can get some rest
- Inpatient Respite Care: Up to 9 days per calendar year, a short stay in a nursing home or assisted care living facility so the member's caregiver can get some rest
- Personal Emergency Response System: A call button so the member can get help in an emergency when their caregiver is not around
- Pest Control: Up to 9 units per calendar year, spraying the member's home for bugs or mice
- Minor Home Modifications: Up to $6,000 per project; $10,000 per calendar year; and $20,000 per lifetime, certain changes to the member's home that will help them get around easier and safer in their home like grab bars or a wheelchair ramp

Click here to review the Group 3 Benefit chart. Please see Pages 103-106

TennCare Benefits

The need for one-time CHOICES HCBS is not sufficient to meet medical necessity of care for HCBS. If a member's ongoing need for assistance with activities of daily living and/or instrumental activities of daily living can be met, as determined through the needs assessment and care planning processes, through the provision of assistance by family members and/or other caregivers, or through the receipt of services available to the member through community resources (e.g., Meals on Wheels) or other payer sources (e.g., Medicare), the member does not require HCBS in order to continue living safely in the home and community-based setting and to prevent or delay placement in a nursing facility.

Some of the TennCare benefits include:

- Home Health Services: Home health services for adults aged 21 and older are limited to 8 hours per day and 27 hours per week of nursing care, with a limit of 30 hours per week for enrollees who qualify for skilled nursing facility care. Home health aide and home health nursing services combined are limited to 8 hours per day and 35 hours per week, with a limit of 40 hours per week for enrollees who qualify for skilled nursing facility care.
- Occupational Therapy
- Physical Therapy Services
- Pharmacy Services
- Non-Emergency Transportation

TennCare Benefit packages L & M linked here.

What does TennCare Need for a Safety Determination Review?

Documentation Requirements

- **Completed Safety Determination Form**
  - At a minimum one justification must be selected for review
  - Supporting documentation may consist of, but is not limited to, narrative descriptions or explanations from submitter, caregivers, or family members; hospital notes, therapy notes, MD visits, ADL flow sheets, encounter notes from nurses, therapists, or physicians; and any other documents which would demonstrate the safety concern(s) for the applicant.

- **Comprehensive Needs Assessment**
  - Assessment of the applicants physical, behavioral and psychosocial needs
  - 6 month history of care, services and living arrangements
  - Explanation of recent events which may have triggered a safety concern

- **Plan of Care**

- **Safety Explanation**

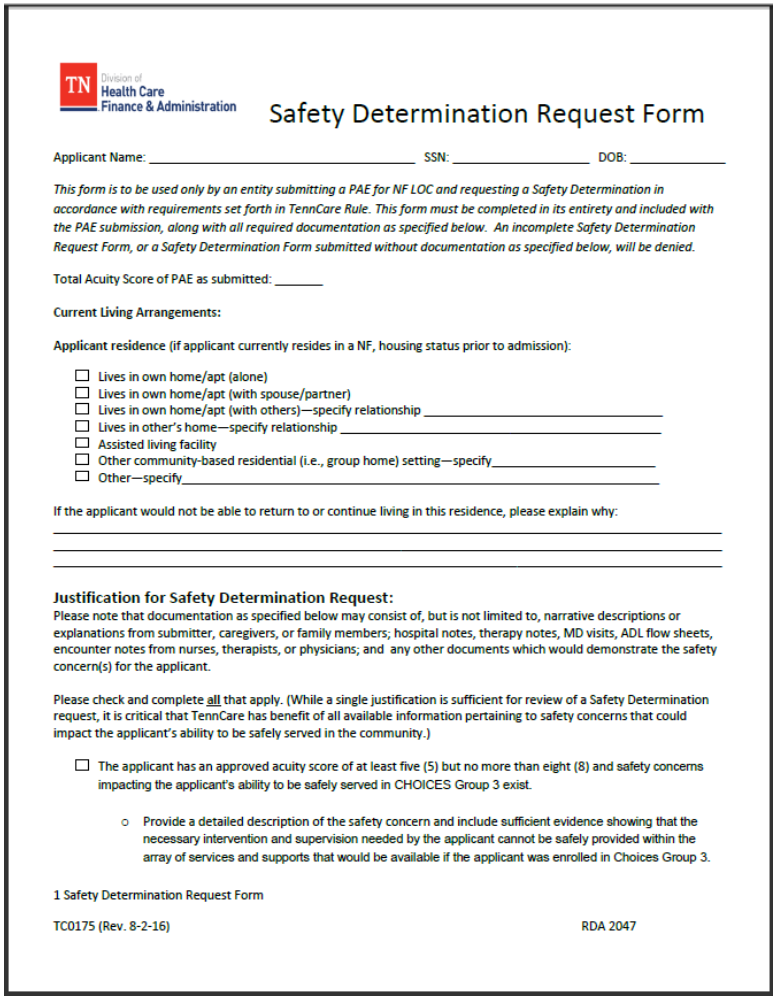
- **Any other documentation that may show why the person's needs can't be met if enrolled in Group 3, even with all Group 3 and TennCare benefits**

**The next few slides will detail each of these requirements.*

Safety Determination Request Form

When compiling the supporting documentation for a Safety Determination request utilize the "Safety Determination Request Form" found **here.**

The qualified assessor will be able to select justifications for the safety request and provide descriptions of why that justification was selected. The requests on the "Safety Determination Request Form" should mirror the requests entered into TPAES on the Safety Determination Request tab. The assessor does not have to complete the sections that were not checked. This form must be uploaded on the PAE when a safety determination is requested. It should be labeled as "Safety Determination Request Form"



TN Division of Health Care Finance & Administration

Safety Determination Request Form

Applicant Name: _____ SSN: _____ DOB: _____

This form is to be used only by an entity submitting a PAE for NF LOC and requesting a Safety Determination in accordance with requirements set forth in TennCare Rule. This form must be completed in its entirety and included with the PAE submission, along with all required documentation as specified below. An incomplete Safety Determination Request Form, or a Safety Determination Form submitted without documentation as specified below, will be denied.

Total Acuity Score of PAE as submitted: _____

Current Living Arrangements:

Applicant residence (if applicant currently resides in a NF, housing status prior to admission):

- ☐ Lives in own home/apt (alone)
- ☐ Lives in own home/apt (with spouse/partner)
- ☐ Lives in own home/apt (with others)—specify relationship _____
- ☐ Lives in other's home—specify relationship _____
- ☐ Assisted living facility
- ☐ Other community-based residential (i.e., group home) setting—specify_____
- ☐ Other—specify_____

If the applicant would not be able to return to or continue living in this residence, please explain why:

_____
_____
_____

Justification for Safety Determination Request:

Please note that documentation as specified below may consist of, but is not limited to, narrative descriptions or explanations from submitter, caregivers, or family members; hospital notes, therapy notes, MD visits, ADL flow sheets, encounter notes from nurses, therapists, or physicians; and any other documents which would demonstrate the safety concern(s) for the applicant.

Please check and complete **all** that apply. (While a single justification is sufficient for review of a Safety Determination request, it is critical that TennCare has benefit of all available information pertaining to safety concerns that could impact the applicant's ability to be safely served in the community.)

- ☐ The applicant has an approved acuity score of at least five (5) but no more than eight (8) and safety concerns impacting the applicant's ability to be safely served in CHOICES Group 3 exist.
  - ○ Provide a detailed description of the safety concern and include sufficient evidence showing that the necessary intervention and supervision needed by the applicant cannot be safely provided within the array of services and supports that would be available if the applicant was enrolled in Choices Group 3.

1 Safety Determination Request Form

TC0175 (Rev. 8-2-16) RDA 2047

Safety Determination Justifications

One of the following justifications MUST be selected on the Safety Determination Form along with documentation to support the justification when submitting a safety determination request:

- The applicant has an approved **total acuity score of at least five (5) but no more than eight (8)** and safety concerns impacting the applicant's ability to be safely served in CHOICES Group 3 exist.

- The applicant has an individual acuity score of at least 3 for the mobility or transfer measures **and** the absence of frequent intermittent assistance for mobility or transfer needs would result in imminent and serious risk to the applicant's health and safety.

  Describe how often mobility and/or transfer assistance is needed by the member and the availability of paid and unpaid caregivers to provide such assistance, including any recent changes in the applicant's needs and/or availability of caregivers to meet such needs.

- The applicant has an individual acuity score of at least 2 for the toileting measure, **and** the absence of frequent intermittent assistance for toileting needs would result in imminent and serious risk to the applicant's health and safety

  Describe how often toileting assistance is needed by the member and the availability of paid and unpaid caregivers to provide such assistance, including any recent changes in the applicant's needs and/or availability of caregivers to meet such needs.

Safety Determination Justifications

- The applicant has an individual acuity score of at least 3 for the Orientation measure **and** the absence of frequent intermittent or continuous intervention and supervision would result in imminent and serious risk of harm to the applicant and/or others.

Provide a detailed description of how orientation deficits impact the applicant's safety, including information or examples that would support and describe the imminence and seriousness of risk.

**Example: An individual who can no longer ambulate independently attempts to get up out of bed every morning without assistance, this individual is not oriented to event/situation and this disorientation could result in serious risk or harm.

- The applicant has an individual acuity score of at least 2 for the Behavior measure **and** the absence of intervention and supervision for behaviors at the frequency specified in the PAE would result in imminent and serious risk of harm to the Applicant and/or others. Provide a detailed description of the specific behavior(s), the frequency of each behavior, and information and/ or examples which support and describe the imminence and seriousness of risk resulting from the behavior(s).

** Example: If a person whose behaviors have led him or her to go outside with minimal clothing in the wintertime or to walk into the middle of a busy street, this could result in serious risk or harm.

- The **applicant** has experienced a significant change in physical or behavioral health or functional needs.

Safety Determination Justifications

- Applicant's **primary caregiver** has experienced a significant change in physical or behavioral health or functional needs which impacts the availability of needed assistance for the applicant.
- Applicant has a pattern of recent falls resulting in injury or with significant potential for injury or a recent fall under circumstances indicating a significant potential risk for further falls.
- The Applicant has an established **pattern of recent emergent hospital admissions** or emergency department utilization for emergent conditions or a recent hospital or NF admission or episode of treatment in a hospital emergency department under circumstances sufficient to indicate that the person may not be capable of being safely maintained in the community (not every hospital or NF admission or ER episode will be sufficient to indicate such).
- The applicant's behaviors or a pattern of self-neglect has created a risk to personal health, safety and/or welfare requiring involvement by law enforcement or Adult Protective Services.

Safety Determination Justifications

- The applicant has recently been **discharged from a community-based residential alternative setting** (or such discharge is pending) because the Applicant's needs can no longer be safely met in that setting.

- The applicant has **diagnosed complex acute or chronic medical conditions** which require frequent, ongoing skilled and/or rehabilitative interventions and treatment by licensed professional staff.

- The applicant requires post- acute inpatient treatment for a specified period of time to allow for stabilization, rehabilitation or intensive teaching in order to facilitate a safe transition into the community.

Safety Determination Justifications

- The applicant's MCO has determined, upon enrollment into Group 3 based on a PAE submitted by another entity, that the applicant's needs cannot be safely met within the array of services and supports available if enrolled in Group 3.

- None of the criteria above have been met, but other safety concerns which impact the applicant being safely served in CHOICES Group 3 exist.

  Provide a detailed description of the safety concern and include sufficient evidence showing that the necessary intervention and supervision needed by the applicant cannot be safely provided within the array of services and supports that would be available if the applicant was enrolled in Choices Group 3.

- The applicant is a current CHOICES Group 1 or 2 member or PACE member enrolled on or after 7/1/2012 and has been determined upon review to no longer meet NF LOC requirements based on a total acuity score of 9 or above, but because of specific safety concerns, still requires the level of care currently being provided. Safety justification and associated documentation must be represented in at least one of the areas listed above.

Comprehensive Needs Assessment

What is a comprehensive needs assessment?

- ✓ An assessment of the applicant's physical, behavioral, and psychosocial needs not reflected in the PAE; the specific tasks and functions for which assistance is needed by the applicant; the frequency with which such tasks must be performed; and the applicant's need for safety monitoring and supervision;
- ✓ The Applicant's living arrangements and the services and supports the Applicant has received during the six (6) months prior to submission of the Safety Determination request, including unpaid care provided by family members and other caregivers, paid services and supports the Applicant has been receiving regardless of payer (e.g., non-CHOICES HCBS available through TennCare such as home health and services available through Medicare, private insurance or other funding sources); and any anticipated change in the availability of such care or services from the current caregiver or payer; and
- ✓ A detailed explanation regarding any recent significant event(s) or circumstances that have impacted the Applicant's need for services and supports, including how such event(s) or circumstances impact the Applicant's ability to be safely supported within the array of covered services and supports that would be available if the Applicant were enrolled in CHOICES Group 3

Plan of Care

What is a plan of care?

A person-centered plan of care developed by the MCO Care Coordinator, NF, or PACE Organization (i.e., the entity submitting the Safety Determination request).

Specifies the following:

- ✓ The tasks and functions for which assistance is needed by the Applicant,
- ✓ The frequency with which such tasks must be performed,
- ✓ The applicant's need for safety monitoring and supervision;
- ✓ The amount (e.g., minutes, hours, etc.) of paid assistance that would be necessary to provide such assistance; and that would be provided by such entity upon approval of the Safety Determination.

In the case of a Safety Determination request submitted by an MCO or AAAD for a NF resident, the plan of care shall be developed in collaboration with the NF, as appropriate. To the extent that all of the required information is not specified in a NF Plan of Care, the NF should still attach the Plan of Care, along with additional documentation regarding tasks and functions, frequency, etc., that will help to describe why the person's needs cannot be safely met in CHOICES Group 3, and why the higher level of care is appropriate.

A plan of care is not required for a Safety Determination submitted by the AAAD

Safety Explanation

What is a safety explanation?

A detailed explanation regarding why the array of covered services and supports, including CHOICES HCBS up to the Expenditure Cap of $15,000 and non- CHOICES HCBS (e.g., home health), services available through Medicare, private insurance or other funding sources, and unpaid supports provided by family members and other caregivers would not be sufficient to safely meet the applicant's needs in the community

You must answer the question:
Why can't the applicant's needs be met within Group 3?

Safety Assessment Tab Walkthrough

Cheat Sheets

Safety Assessment Tab

Functional Assessment

ACTIVITIES OF DAILY LIVING (ADL) OR ADL RELATED FUNCTIONS

Note: Only a Qualified Assessor is able to complete a functional assessment.

Activities of Daily Living

Transfer

Mobility

Eating

Toileting

Medication Administration

Activity of Daily Living Related Conditions

Communication

Orientation

Behaviors

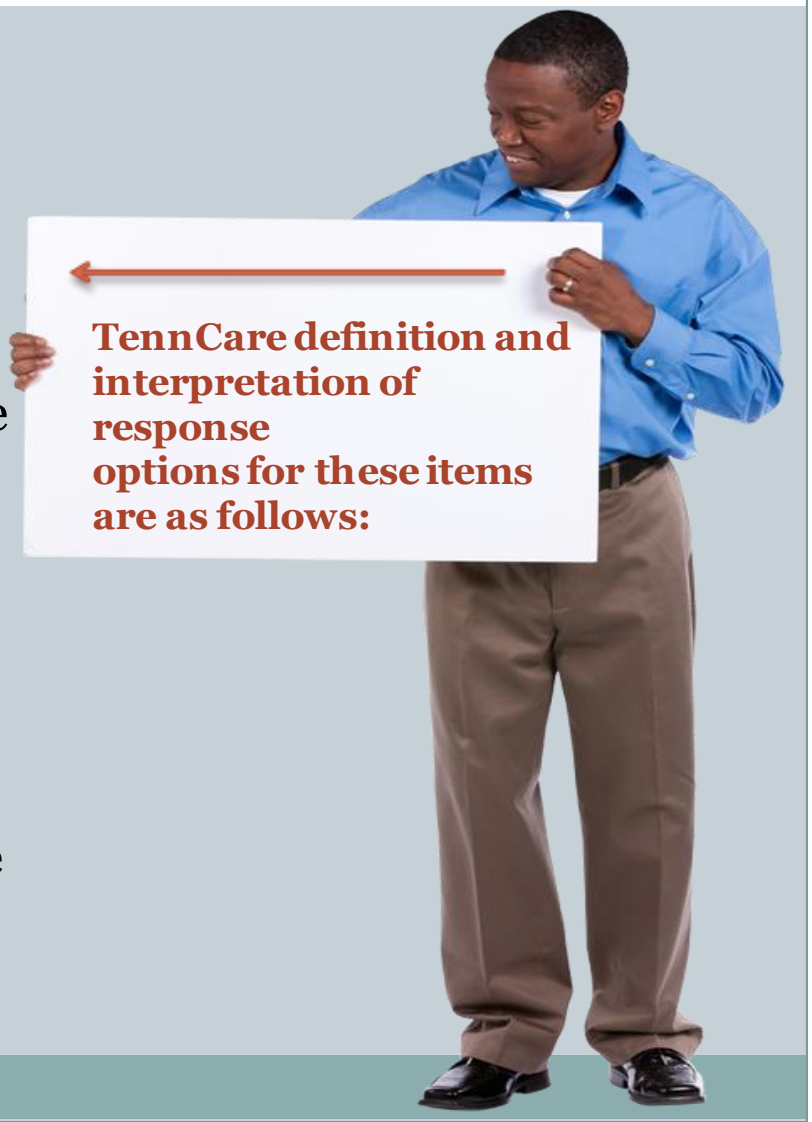
Measuring Deficits

Always: Always performs function independently

Usually: requires assistance only 1-3 days per week

Usually Not: requires assistance 4 or more days per week

Never: Never performs function independently



- Please note: For the area of Behaviors the definitions listed above are reversed

Transfer

- Defined per TennCare Rule 1200-13-01:

The Applicant is incapable of transfer to and from bed, chair, or toilet unless physical assistance is provided by others on an ongoing basis (daily or at least four days per week).

Approval of this deficit shall require documentation of the medical condition(s) contributing to this deficit, as well as the specific type and frequency of transfer assistance required.

This is moving the body from one place to another without ambulating (which is covered under the Mobility section). It is important to note the rule applies to bed, chair, or toilet only. An example may be the applicant needs someone to hold on to him when he is getting up/down from the bed and on/off the toilet.

Recommended documentation to support this functional deficit:
H&P, Plan of Care, ADL flow sheets, PT notes, nurse's notes, section "G" of MDS, HCBS Tools (Applicant and Collateral tools)

Helpful Hint: Transfer

Click **here** to Return to Transfer Rule
Click **here** to move on to Mobility Rule

Mobility

- Defined by TennCare Rule 1200-13-01:

The applicant requires physical assistance from another person for mobility on an ongoing basis. A significant deficit is daily or at least four days per week. Mobility is defined as the ability to walk, using mobility aids such as a walker, crutch, or cane if required, or the ability to use a wheelchair if walking is not feasible. The need for a wheelchair, walker, crutch, cane, or other mobility aid shall not by itself be considered to meet this requirement.

Approval of this deficit shall require documentation of the medical condition(s) contributing to this deficit, as well as the specific type and frequency of mobility assistance required.

This is the act of moving from one place to another including the ability to walk, using mobility aids such as a walker, crutch, or cane if required, or the ability to use a wheelchair if walking is not feasible. In other words, if someone is able to get from one place to another using their manual or power wheelchair, this would be considered "mobile". An example may be the applicant needs someone to hold on to him when he is ambulating with his cane.

Recommended documentation to support this functional deficit:
H&P, Plan of Care, ADL flow sheets, PT notes, nurse's notes, section "G" of MDS, HCBS tools

Helpful Hint: Mobility

Click here to Return to Mobility Rule
Click here to move on to Eating Rule

Eating

- Defined per TennCare Rule 1200-13-01:

The Applicant requires physical assistance with gastrostomy tube feedings or physical assistance or constant one-on-one observation and verbal assistance (reminding, encouraging) 4 or more days per week to consume prepared food and drink (or self-administer tube feedings, as applicable) or must be fed part or all of each meal. Food preparation, tray set-up, assistance in cutting up foods, and general supervision of multiple residents shall not be considered to meet this requirement.

Approval of this deficit shall require documentation which supports the need for such intervention, along with evidence that in the absence of such physical assistance or constant one-on-one observation and verbal assistance, the Applicant would be unable to self-perform this task. For PAEs submitted by the AAAD (or entity other than an MCO, NF, or PACE Organization), an eating or feeding plan specifying the type, frequency and duration of supports required by the Applicant for feeding, along with evidence that in the absence of such physical assistance or constant one-on-one observation and verbal assistance, the Applicant would be unable to self-perform this task shall be required.

An example may be the applicant needs someone to place food/drink in his/her mouth. Or the applicant requires constant one-on-one observation and verbal assistance to eat.

Recommended documentation to support this functional deficit: H&P, Plan of Care, ADL flow sheets, OT/ST notes, nurse's notes, swallow study, section "G" of MDS, HCBS tools

Helpful Hint: Eating

Click here to Return to Eating Rule
Click here to move on to Toileting Rule

Toileting

- Defined per TennCare Rule 1200-13-01:

The Applicant requires physical assistance from another person to use the toilet or to perform incontinence care, ostomy care, or catheter care on an ongoing basis (daily or at least four days per week).

Approval of this deficit shall require documentation of the specific type and frequency of toileting assistance required.

Includes the act of toileting, adjusting clothing and/or being able to properly clean oneself. This does NOT include the act of getting on/off toilet as this is accounted for in the Transfer question already. Incontinence is scored separately, for example someone may usually be able to toilet but is incontinent and can never clean themselves. Some people can have an indwelling catheter and care for it themselves, do not assume the presence of one means the person is Never able to self-care.

Recommended documentation to support this functional deficit:
H&P, Plan of Care, ADL flow sheets, nurse's notes, section "G" of MDS, HCBS tools

Helpful Hint: Toileting

Click here to Return to Toileting Rule
Click here to move on to Orientation Rule

Orientation

- Defined per TennCare Rule 1200-13-01:

The Applicant is disoriented to person (e.g., fails to remember own name, or recognize immediate family members), place (e.g., does not know residence is a NF), or event/situation (e.g., is unaware of current circumstances in order to make decisions that prevent risk of harm) daily or at least four days per week.

Approval of this deficit shall require documentation of the specific orientation deficit(s), including the frequency of occurrence of such deficit(s), and the impact of such deficit(s) on the Applicant.

Please note that the definition is for disorientation to person, place, or event/situation; this does NOT include such things as time, or people who are not immediate family. An example may be the applicant does not know who he/she is and/or where he/she is or they are unable to make decisions that prevent risk of harm.

Recommended documentation to support this functional deficit:
H&P, Plan of Care, Nurse's notes, psych notes, mini-mental status exam, SLUMS, HCBS tools

Helpful Hint: Orientation

Click here to Return to Orientation Rule
Click here to move on to Communication Rule

Communication

- Defined per TennCare Rule 1200-13-01:

The Applicant is incapable of reliably communicating basic needs and wants (e.g., need for assistance with toileting; presence of pain) in a manner that can be understood by others, including through the use of assistive devices; or the Applicant is incapable of understanding and following very simple instructions and commands without continual intervention (daily or at least four days per week).

Approval of this deficit shall require documentation of the medical condition(s) contributing to this deficit, as well as the specific type and frequency of communication assistance required.

Expressive:

An example may be the applicant needs help to let others know that he/she needs to use the toilet. Detail if the applicant utilizes a communication assistive device (e.g., Ipad, picture board)

Receptive:

Does not include complex instructions. Can the applicant follow simple instruction within their functional ability?

Recommended documentation to support this functional deficit:
H&P, Plan of Care, ST notes, Nurse's notes, psych notes, mini-mental status exam, SLUMS, HCBS tools

Helpful Hint: Communication

Click here to Return to Communication Rule
Click here to move on to Medication Rule

Medication

- Defined per TennCare Rule 1200-13-01:

The Applicant is not cognitively or physically capable (daily or at least four days per week) of self-administering prescribed medications at the prescribed schedule despite the availability of limited assistance from another person. Limited assistance includes, but is not limited to, reminding when to take medications, encouragement to take, reading medication labels, opening bottles, handing to Applicant, reassurance of the correct dose, and the use of assistive devices including a prepared medication box. An occasional lapse in adherence to a medication schedule shall not be sufficient for approval of this deficit; the Applicant must have physical or cognitive impairments which persistently inhibit his or her ability to self-administer medications.

Approval of this deficit shall require evidence that such interventions have been tried or would not be successful, and that in the absence of intervention, the Applicant's health would be at serious and imminent risk of harm.

Applies to all medications person receives that are to be received long term. If prepared, can the applicant place the medication(s) into his/her mouth or apply patch, inject, etc.

Recommended documentation to support this functional deficit: H&P, Plan of Care, Order/prescription for medications listed as unable to self-administer, MAR, Nurse's notes, ST notes, MDS, HCBS tools

Helpful Hint: Medication

Click here to Return to Medication Rule
Click here to move on to Behavior Rule

Behavior

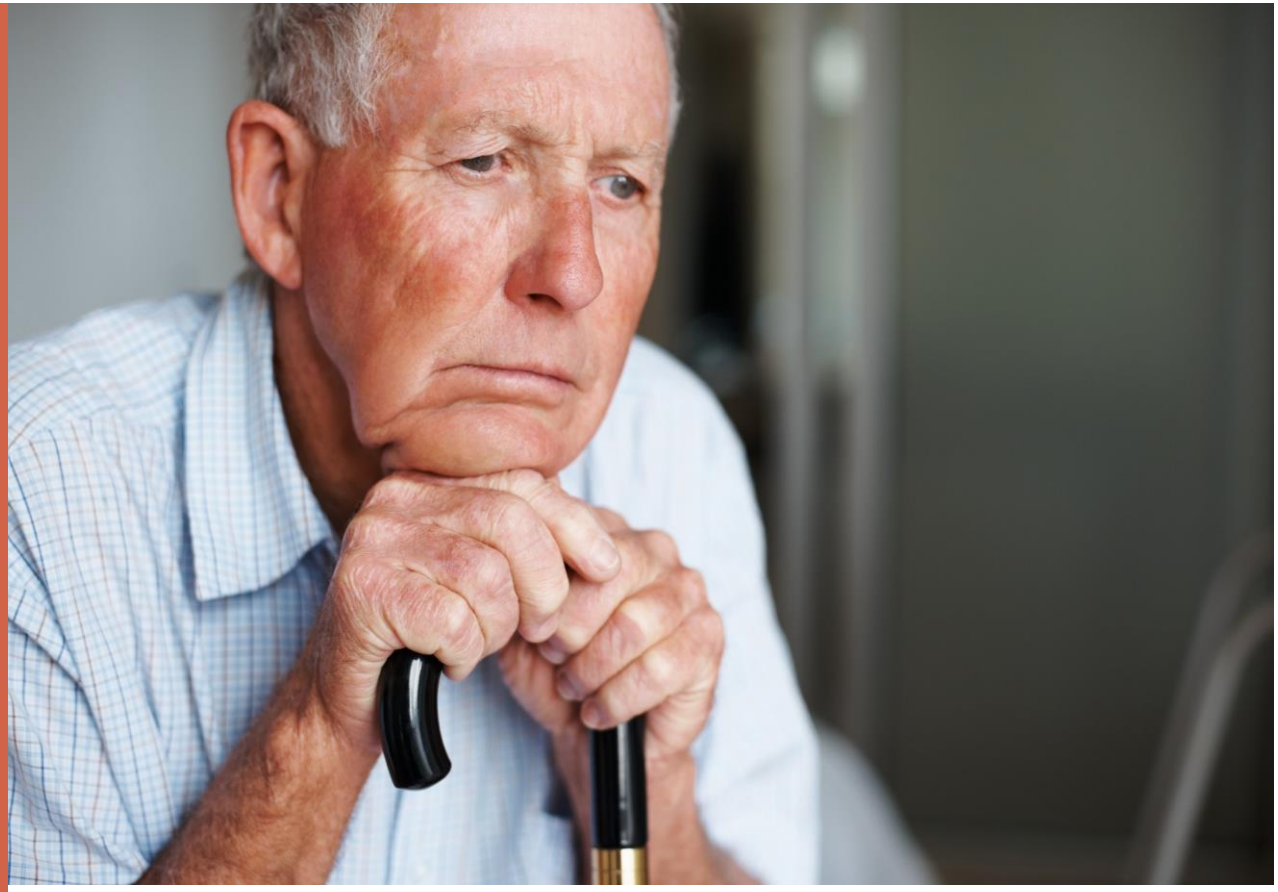
- Defined per TennCare Rule 1200-13-01:

The Applicant requires persistent staff or caregiver intervention and supervision (daily or at least four days per week) due to an established and persistent pattern of behavioral problems which are not primarily related to a mental health condition (for which mental health treatment would be the most appropriate course of treatment) or a substance abuse disorder (for which substance abuse treatment would be the most appropriate course of treatment), and which, absent such continual intervention and supervision, place the Applicant or others at imminent and serious risk of harm. Such behaviors may include physical aggression (including assaultive or self-injurious behavior, destruction of property, resistive or combative to personal and other care, intimidating/threatening, or sexual acting out or exploitation) or inappropriate or unsafe behavior (including disrobing in public, eating non-edible substances, fire setting, unsafe cooking or smoking, wandering, elopement, or getting lost).

Approval of this deficit shall require documentation of the specific behaviors and the frequency of such behaviors.

Notice answers are in reverse from previous options, “Always” referring to the person requires intervention. An example may be the applicant needs someone to intervene daily when he/she attempts to strike their caregiver.

Recommended documentation to support this functional deficit: H&P, Plan of Care, Documented diagnosis, Nurse’s notes, psych notes, HCBS tools



Helpful Hint: Behavior

Click here to Return to Behavior Rule
Click here to move on to Skilled Services

Functional Assessment

Cheat Sheets

Functional Assessment

Skilled Services & Enhanced Respiratory Care

Skilled Services – The Process

What happens if…

an applicant requires one or more specified skilled nursing or rehabilitative services?

1. The submitter should complete the Nursing & Rehabilitative Services tab in TPAES and attach documentation required
2. For nursing facility requests information is used to determine medical eligibility for Skilled Services or Enhanced Respiratory Care reimbursement.
3. For HCBS requests this information is used to determine the person's individual cost neutrality cap.

Skilled Services Documentation

- For HCBS PAEs a Physician's Order will **not** be required if the skilled or rehabilitative services are being performed by a family member under a specified exemption to the Nurse Practice Act.

- The request must include medical records sufficient to document the need for each skilled or rehabilitative service(s), including the frequency of each service, as would be required for determination of eligibility of a higher level of NF reimbursement.

- The required supporting documentation as well as length of approval guidelines used by TennCare can be found **here**

Skilled Services

- Ventilator (Does not include vent weaning services)
- Nasopharyngeal suctioning
- Infrequent tracheal suctioning
- Total Parenteral Nutrition
- Complex wound care (e.g., infected wounds, dehisced wounds, 3 or more stage 3 and/or stage 4 wounds
- Wound care for stage 3 or 4 decubitus
- Peritoneal Dialysis
- Tube feeding, enteral
- Intravenous fluid administration
- Injections, sliding scale

Skilled Services

- Injections, other IV, IM
- Isolation precautions
- PCA pump
- Occupational therapy by OT or OT assistant
- Physical therapy by PT or PT assistant
- Teaching catheter/ ostomy care
- Teaching self injection

Enhanced Respiratory Care

Secretion Management Tracheal Suctioning

- The applicant must have a functioning tracheostomy, have a copious volume of secretions (defined as 25-30cc per day). Secretion Management (invasive tracheal suctioning) is one of 2 options the use of mechanical airway clearance devices and/or heated high flow molecular humidification via the trach at a minimum of 3 times per day.

Enhanced Respiratory Care

Chronic Ventilator reimbursement

- The applicant must be ventilator dependent at least 12 hours per day or the use of a NIPPV to delay tracheostomy for progressive neurological disorders.

Rehabilitative Services

TennCare does not provide reimbursement for the following rehabilitative services

- Chronic conditions
- Exacerbations of chronic conditions
- Weakness after hospitalization
- Rehabilitative services for maintenance of functional status (e.g., routine range of motion exercises, etc.) are not considered skilled level services.

PAE Submissions and Skilled Services

- If a PAE is approved *without* the acuity points associated with a skilled service, the PAE does not end (only the skilled service ends).

- If acuity points from a skilled service allow for the PAE approval, the PAE will end with the end date of the approved skilled service.

PAE Submissions and Skilled Services

- If the PAE has an end date and there is a need to continue the NF care or HCBS, the PAE submitter would submit a new PAE through TPAES.

- Skilled Services may be requested on the PAE for purposes of calculating the acuity score for level of care determinations.

Extend Skilled Services

- Skilled services cannot extended through TPAES.

Extend Enhanced Respiratory Care

- Enhanced Respiratory Care can be extended through TPAES.

- The PAE submitter will be able to request to extend Enhanced Respiratory Care on PAEs with Approved Enhanced Respiratory Care Services by hitting a button- *"Extend Enhanced Respiratory Care Reimbursement"*.

Extend Enhanced Respiratory Care

- There are no limits made to the number of times that ERC can be extended.
- No lifetime max number of days should apply to the PAE and/or applicant, if within the approved dates of the PAE.

Enter Skilled Services/ERC

Cheat Sheets

Enter Skilled Services/ERC

Extending Skilled Services/ERC

Finalizing Your PAE

Finalizing your PAE

Cheat Sheets

Attaching Documents

M
O
P
D

Medicaid Only Payer Date & Admit Date

Medicaid Only Payer Date (MOPD)

- **Medicaid Only Payer Date (MOPD)-**The date a NF certifies that Medicaid reimbursement for NF services will begin because the applicant has been admitted to the facility and all other primary sources of reimbursement (including Medicare and private pay) have been exhausted.
- The MOPD **must** be known (and not projected) as it will result in the determination of eligibility for Medicaid reimbursement of NF services and in many cases, eligibility for Medicaid, as well as a capitation payment to an MCO and payments for Medicaid services received.
- The PAE may be submitted without a MOPD date in which case the MOPD shall be submitted by the facility when it is known.
- Enrollment into CHOICES Group 1 and eligibility for TennCare reimbursement of NF services shall be permitted only upon submission of a MOPD. The effective date of CHOICES enrollment and Medicaid reimbursement of NF services shall not be earlier than the MOPD.

Admit Date

- LOC determined through the PASRR process require an Admit Date entered into PathTracker in lieu of the MOPD.
- Training on this process can be found at Ascend's website here: https://www.ascendami.com/ami/Providers/YourState/TennesseePASRRUserTools.aspx

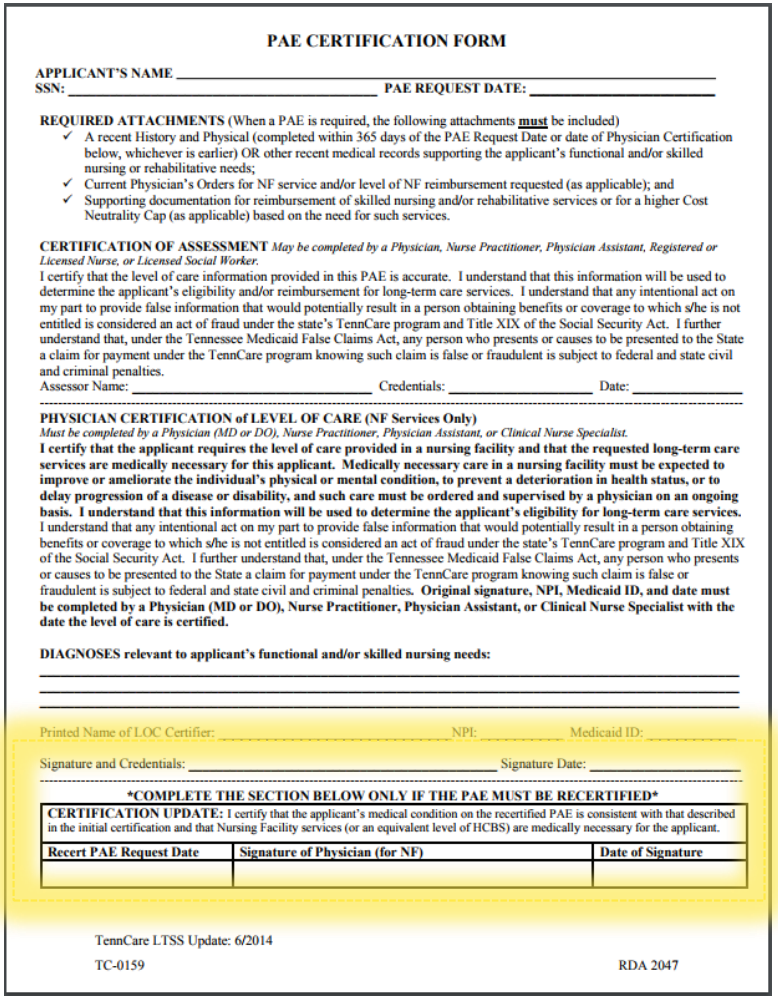
Recertification

Read all about it!

- An approved PAE is valid for 365 days beginning with the PAE approval date unless an earlier expiration date has been established by TennCare.
- A valid approved PAE that has not been used to enroll and reimburse within ninety (90) calendar days of the PAE approval date must be recertified before it can be used.
- For Nursing facility PAEs the MOPD must be entered to recertify a PAE. The MOPD is used to determine if 90 calendar days have passed.
- To recertify the PAE, the physician (nursing facility) shall certify that the applicant's medical condition on the PAE is consistent with that described in the initial certification and that nursing facility services continue to be medically necessary for the applicant.
- If the medical condition of the patient has changed from the original PAE submission a new PAE submission will be required.
- A PAE that is not used within 365 days of the PAE approval date shall expire and cannot be recertified.

For more infomation please see RULE linked *here*

Recertification (cont.)



PAE CERTIFICATION FORM

APPLICANT'S NAME _____
SSN: _____ **PAE REQUEST DATE:** _____

REQUIRED ATTACHMENTS (When a PAE is required, the following attachments **must** be included)

- ✓ A recent History and Physical (completed within 365 days of the PAE Request Date or date of Physician Certification below, whichever is earlier) OR other recent medical records supporting the applicant's functional and/or skilled nursing or rehabilitative needs;
- ✓ Current Physician's Orders for NF service and/or level of NF reimbursement requested (as applicable); and
- ✓ Supporting documentation for reimbursement of skilled nursing and/or rehabilitative services or for a higher Cost Neutrality Cap (as applicable) based on the need for such services.

CERTIFICATION OF ASSESSMENT *May be completed by a Physician, Nurse Practitioner, Physician Assistant, Registered or Licensed Nurse, or Licensed Social Worker.*
I certify that the level of care information provided in this PAE is accurate. I understand that this information will be used to determine the applicant's eligibility and/or reimbursement for long-term care services. I understand that any intentional act on my part to provide false information that would potentially result in a person obtaining benefits or coverage to which s/he is not entitled is considered an act of fraud under the state's TennCare program and Title XIX of the Social Security Act. I further understand that, under the Tennessee Medicaid False Claims Act, any person who presents or causes to be presented to the State a claim for payment under the TennCare program knowing such claim is false or fraudulent is subject to federal and state civil and criminal penalties.
Assessor Name: _____ Credentials: _____ Date: _____

PHYSICIAN CERTIFICATION of LEVEL OF CARE (NF Services Only)
Must be completed by a Physician (MD or DO), Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist.
I certify that the applicant requires the level of care provided in a nursing facility and that the requested long-term care services are medically necessary for this applicant. Medically necessary care in a nursing facility must be expected to improve or ameliorate the individual's physical or mental condition, to prevent a deterioration in health status, or to delay progression of a disease or disability, and such care must be ordered and supervised by a physician on an ongoing basis. I understand that this information will be used to determine the applicant's eligibility for long-term care services. I understand that any intentional act on my part to provide false information that would potentially result in a person obtaining benefits or coverage to which s/he is not entitled is considered an act of fraud under the state's TennCare program and Title XIX of the Social Security Act. I further understand that, under the Tennessee Medicaid False Claims Act, any person who presents or causes to be presented to the State a claim for payment under the TennCare program knowing such claim is false or fraudulent is subject to federal and state civil and criminal penalties. **Original signature, NPI, Medicaid ID, and date must be completed by a Physician (MD or DO), Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist with the date the level of care is certified.**

DIAGNOSES relevant to applicant's functional and/or skilled nursing needs:
_____
_____
_____

Printed Name of LOC Certifier: _____ NPI: _____ Medicaid ID: _____

Signature and Credentials: _____ Signature Date: _____

COMPLETE THE SECTION BELOW ONLY IF THE PAE MUST BE RECERTIFIED

CERTIFICATION UPDATE: I certify that the applicant's medical condition on the recertified PAE is consistent with that described in the initial certification and that Nursing Facility services (or an equivalent level of HCBS) are medically necessary for the applicant.

Recert PAE Request Date	Signature of Physician (for NF)	Date of Signature

TennCare LTSS Update: 6/2014
TC-0159 RDA 2047

When requesting recertification use the original PAE Certification Form (do not use a new Certification Form), complete the recertification section found at the bottom of the form, and attach the form to the original PAE.

Examples

NF submits a PAE that is approved on 7/1/12. On 12/1/12, the NF enters the MOPD. The MOPD is 8/1/12. In this case, the NF does NOT have to recertify the PAE.

NF submits a PAE that is approved on 7/1/12. On 6/1/13, the NF enters the MOPD. The MOPD is 12/1/12. In this case, the NF has to recertify the PAE.

NF submits a PAE that is approved on 7/1/12. On 8/1/13, the NF enters the MOPD. The MOPD is 8/1/13. In this case, the NF has to submit a new PAE.

MOPD & Recertification

Cheat Sheets

MOPD with Recertification

MOPD without Recertification

***LOC submitted to Ascend require an Admit Date entered into PathTracker in lieu of the MOPD. Training on this process can be found at Ascend's website here:* https://www.ascendami.com/ami/Providers/YourState/TennesseePASRRUserTools.aspx

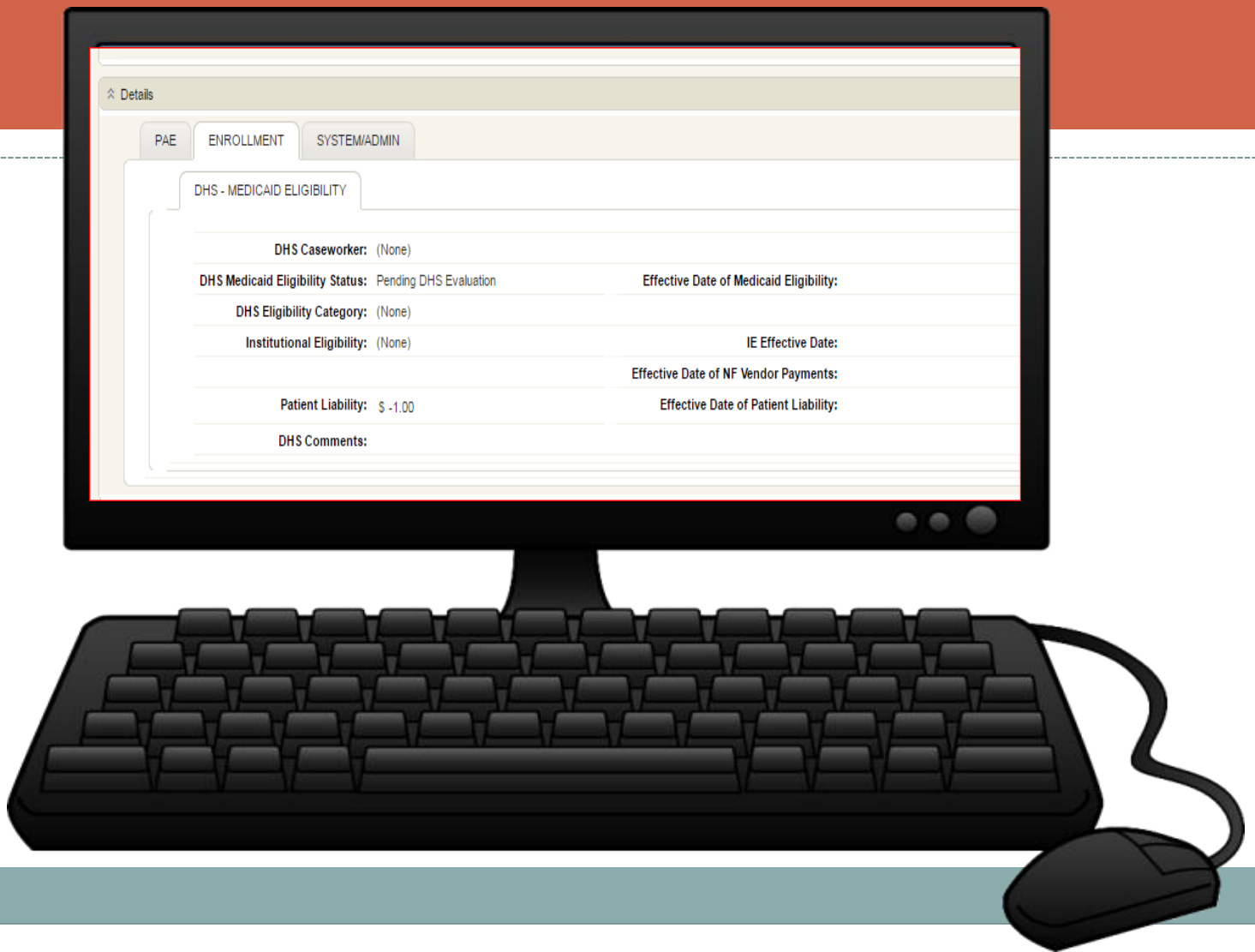
Eligibility and Enrollment

IMPORTANT INFORMATION REGARDING ENROLLMENT INTO AND QUALIFYING FOR A LONG TERM SERVICES AND SUPPORT PROGRAM

Target Population

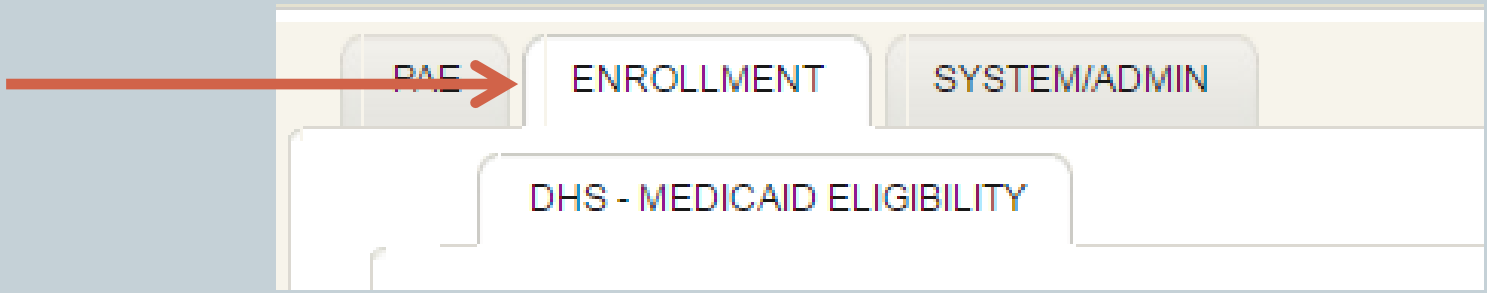
- Target population is defined as persons age sixty-five (65) and older or adults twenty-one (21) and older who have one or more chronic physical disabilities as defined in TennCare Rule. This only applies to Group 3.
- Members must be in the target population to enroll in CHOICES Group 3.

How to View an Enrollment Decision in TPAES



Understanding Financial Eligibility Decisions as documented in TPAES

The Medicaid Eligibility section is housed on the Enrollment tab in TPAES. When Medicaid is approved, providers should verify eligibility using TN Anytime.



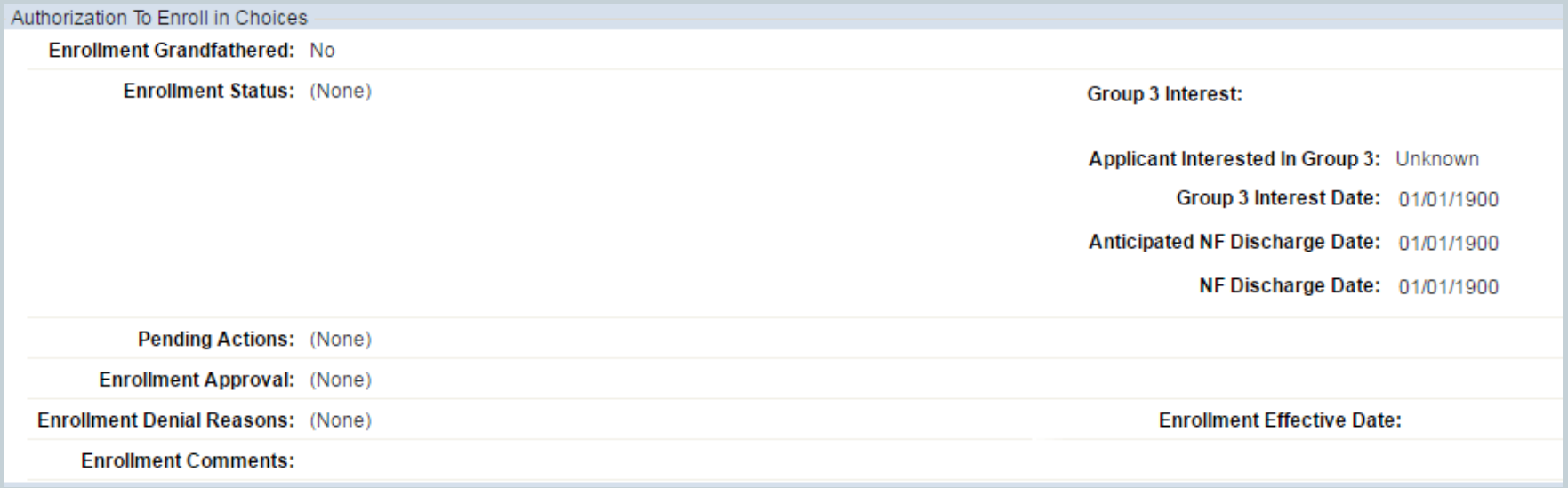
Understanding Financial Eligibility Decisions as documented in TPAES

The chart below shows the Medicaid decision as documented in TPAES by the TennCare financial eligibility caseworker.

Caseworker:	Caseworker TPAES User Name		
Medicaid Eligibility Status:	**Pending** –used to show enrollment decision is waiting for a financial eligibility decision **Approved** –used to show financial eligibility is approved **Denied**- used to show financial eligibility is denied	**Effective Date of Medicaid Eligibility:**	Financial eligibility approval effective date is entered
		IE Effective Date:	Approval effective date of immediate eligibility
Eligibility Category:	Only completed when Medicaid is approved. Used by TennCare enrollment team	**Effective Date of NF Vendor Payments:**	Used to show when TennCare reimbursement of LTSS can begin
Institutional Eligibility:	Only completed when Medicaid is approved. Used by TennCare enrollment team	**Effective Date of Patient Liability:**	Effective date of patient liability obligation
Patient Liability	$ Amount of monthly patient liability obligation		
Comments	Additional comments by eligibility caseworker		

Viewing LTSS Enrollment

Enrollment decisions are housed within the *Authorization to Enroll in CHOICES* section of the PAE. Here you will find enrollment decisions made by LTSS regarding the applicant



Verifying Eligibility & Viewing Approval

Cheat Sheets

Verifying Eligibility

Viewing Approvals

WHAT IF MY REQUEST FOR NURSING FACILITY LEVEL OF CARE IS DENIED?

NF LOC Denial

What does this mean?

A new PAE is not necessary if there is an error in the submission. You may revise the PAE within 30 days. (Note: You cannot revise when the LOC is adjudicated by ASCEND. Please contact ASCEND for a reconsideration

This means….
Medical eligibility for reimbursement through CHOICES 1 & 2 is denied.

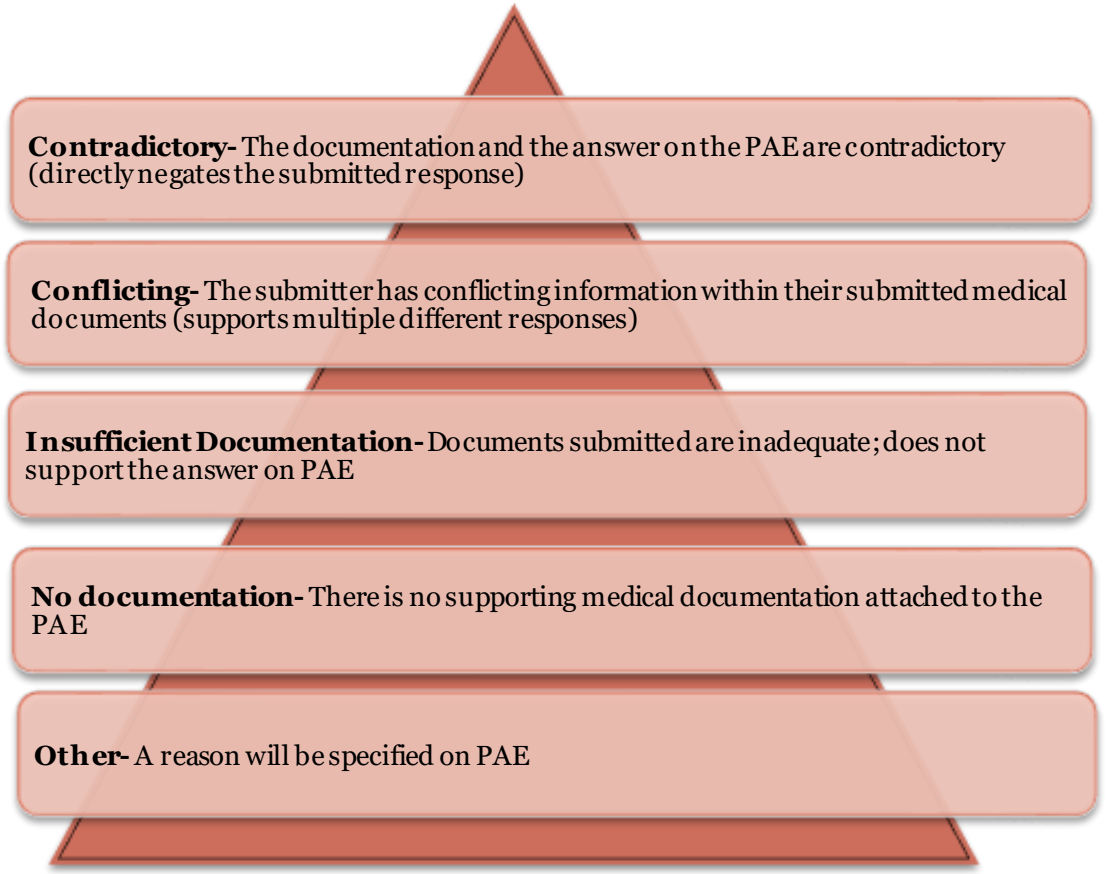
Please note, TennCare may have approved At Risk LOC necessary for Group 3 enrollment so it is important to carefully review the denied PAE.

Denial Reasons

Within your Functional Assessment you will see reasons for each denial. They may include the following…

- **Contradictory documentation**
- **Conflicting documentation**
- **Insufficient documentation**
- **No documentation**
- **Other**

Defining Denial Reasons…what do they mean?



Denial Reasons

There may also be other denial comments made by the LTSS nurse reviewer indicating a more detailed reason for the denial.

Technical denials may occur when:

- The certifier of LOC name is not printed on the submitted certification form
- The assessor codes do not match for HCBS submissions
- The assessor names do not match in TPAES and the applicant interview tool (if submitted)
- The PAE is end dated and a request is submitted to extend the end date
- A PAE that is >30 days from date of denial or over 365 days old (untimely resubmission)
- Attached file does not match applicant name on PAE
- If the wheelchair question is not addressed

Denial Reasons

There may also be other denial comments made by the LTSS nurse reviewer indicating a more detailed reason for the denial.

Medical Necessity Denials may occur when:

- The signed certification page is missing from the submission
- No medical documentation is submitted
- For re-certifications, the certifier of LOC signature and date are missing
- For AAAD HCBS submissions, the ongoing services box is not checked
- For MCO HCBS submissions, the Cost Neutrality tab is not filled out.

Let's Work Together

If the applicant is approved for At Risk LOC and is enrolled in CHOICES Group 3, the NF will be working with the assigned MCO to transition the patient to the community unless the MCO decides the patient can't be safely served.

The MCO is responsible for seeing a CHOICES member within ten (10) days of notification of Group 3 enrollment.

Technical Denial

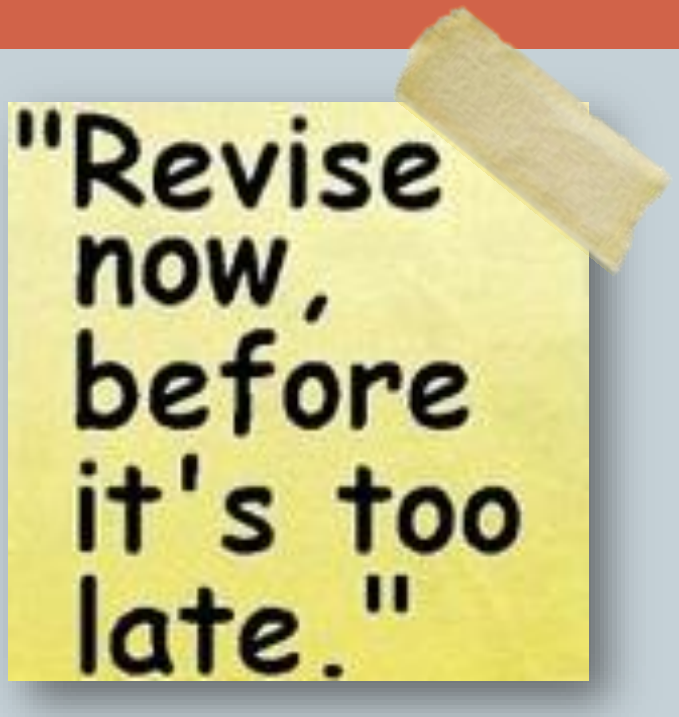
Once a PAE application is submitted to TennCare, the Division of Long Term Services and Supports determines if all technical requirements for submission are met. When a PAE does not meet technical requirements, it is not sent to a TennCare nurse reviewer to determine if other criteria (including LOC) are met. The process ends with a notification to the submitter which is available in TPAES. It lists the reason for the technical denial and remedy options. Typically, the submitter should immediately **REVISE** the PAE to remedy the deficiency noted and resubmit the PAE application.
Technical denials require correction of erroneous or incomplete information and are expected to be immediately corrected by the submitter.

- If the errors are corrected within 30 days of the PAE submission date the PAE will be processed as a new application but information included with the original denied PAE will also be considered with the new determination. This is done by revising the PAE.

- If the revised and corrected PAE is approved, the effective date can be no earlier than the date of receipt of the information/documentation that cured the original deficiencies in the denied PAE.

Revisions

- If you believe the applicant meets medical eligibility requirements, but their PAE is denied, you should revise the PAE and submit documentation that is consistent with the level of deficiency indicated.
- A denied PAE can be revised within thirty (30) days of the denied PAE submission date.
- When a PAE is revised, TennCare reviews both the originally submitted information and the revised information when determining LOC.
- If approved, the effective date of the revised PAE approval can be no more than ten (10) days prior to the date of receipt of the information which cured the original deficiencies in the denied PAE.
- If more than thirty (30) days has passed, the PAE cannot be revised, you must submit a new PAE.



Revisions (cont.)

- **Keep in mind**, If your LOC is denied through the PASRR process you cannot revise that LOC. You will need to contact ASCEND for a reconsideration, or submit a new LOC and PASRR within 30 days
- A safety reconsideration may also be submitted to Ascend at this point in the process
- *Contact the Ascend Help Desk for more information on this process: TNPASRR@ascendami.com or 877-431-1388 x3495*

Denials & Revisions

Cheat Sheets

Reviewing Denials

Revising a PAE – LOC Criteria Denial

Revising a PAE – Technical Denial

Appeals

Appeals Overview

The Appeals process is designed to protect the interests and rights due process for Medicaid applicants and beneficiaries.

TennCare LTSS handles PAE appeals and specific enrollment appeals regarding the denial or termination of enrollment in a long term care program or the denial or termination of participation in CHOICES Consumer Direction.

An individual has 30 days to appeal an adverse action. Appeals must be in writing. If the appeal is not received within the alluded time period the individuals right to a fair hearing is not granted and the appeal is closed.

Note

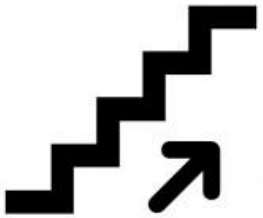
A **technical denial** requires correction of erroneous or incomplete information and is expected to be immediately corrected by the submitter. Additionally, provider payment disputes do not fall under the purview of TennCare, but instead should be brought to the attention of the MCO.

PAE Appeal Process

You may revise the PAE even when an appeal has been filed.

Since the TPAES user (assessor) has access to the medical information to support LOC, it is always recommended that the submitting entity revises a PAE when it is believed that the person meets NF LOC.

Appeal Steps



1. Applicant files written appeal within 30 days of denial notice
2. Appeal received by TennCare LTSS
3. Internal technical and clinical review of original PAE and appeal information to ensure LOC decision is correct
4. Request for additional documentation from NF, as applicable
5. Request to independent contractor for in person assessment
6. TennCare reviews results of assessment and makes an appeal decision
   - Overturns LTSS denial; PAE is approved
   - Upholds LTSS denial; forward appeal to TennCare Office of General Counsel for fair hearing.
7. Written notification of hearing is sent to applicant at least 30 days prior to hearing date

*No Resident may be involuntarily discharged from a NF because of a denied PAE application UNTIL a timely filed appeal is resolved or the time during which an appeal may be requested has passed without action.

Appeals

When a denied PAE is overturned at appeal:

1.) If TennCare made a mistake in the initial PAE review, the PAE approval effective date will be the date that would have been effective had the initial PAE been approved.

2.) If additional medical records were provided with the appeal or by the contractor, the PAE effective date assigned can be no more than 10 days prior to the date the deficiency was cured or remedied by receipt of the additional information.

Please click here to see rule.

The Hearing!

Appeals: Hearing Info

What happens if TennCare's decision is upheld?
The appeal is prepared for hearing.

Hearing info

- A notice is sent to the appellant 30 days in advance of the hearing date and explains the hearing process.
- The hearing typically takes place before an Administrative Law Judge (ALJ) who decides whether or not to uphold TennCare's denial.

After the Hearing

- If the denial is overturned at hearing the PAE is approved and the effective date assigned is no more than 10 days prior to the date the deficiency on the original date is cured.

Did you know!?
In accordance with the *Doe* Consent Decree, a PAE appeal for a NF request is resolved within 90 days. This includes the hearing and final disposition of the case.

**You can find the Doe Consent Decree on TennCare's website.*

Short Term Stay

COVERED BENEFIT FOR GROUP 2 AND GROUP 3 CHOICES MEMBERS INCLUDE A SHORT TERM NF STAY (UP TO 90 DAYS OF MEDICAID REIMBURSED CARE).

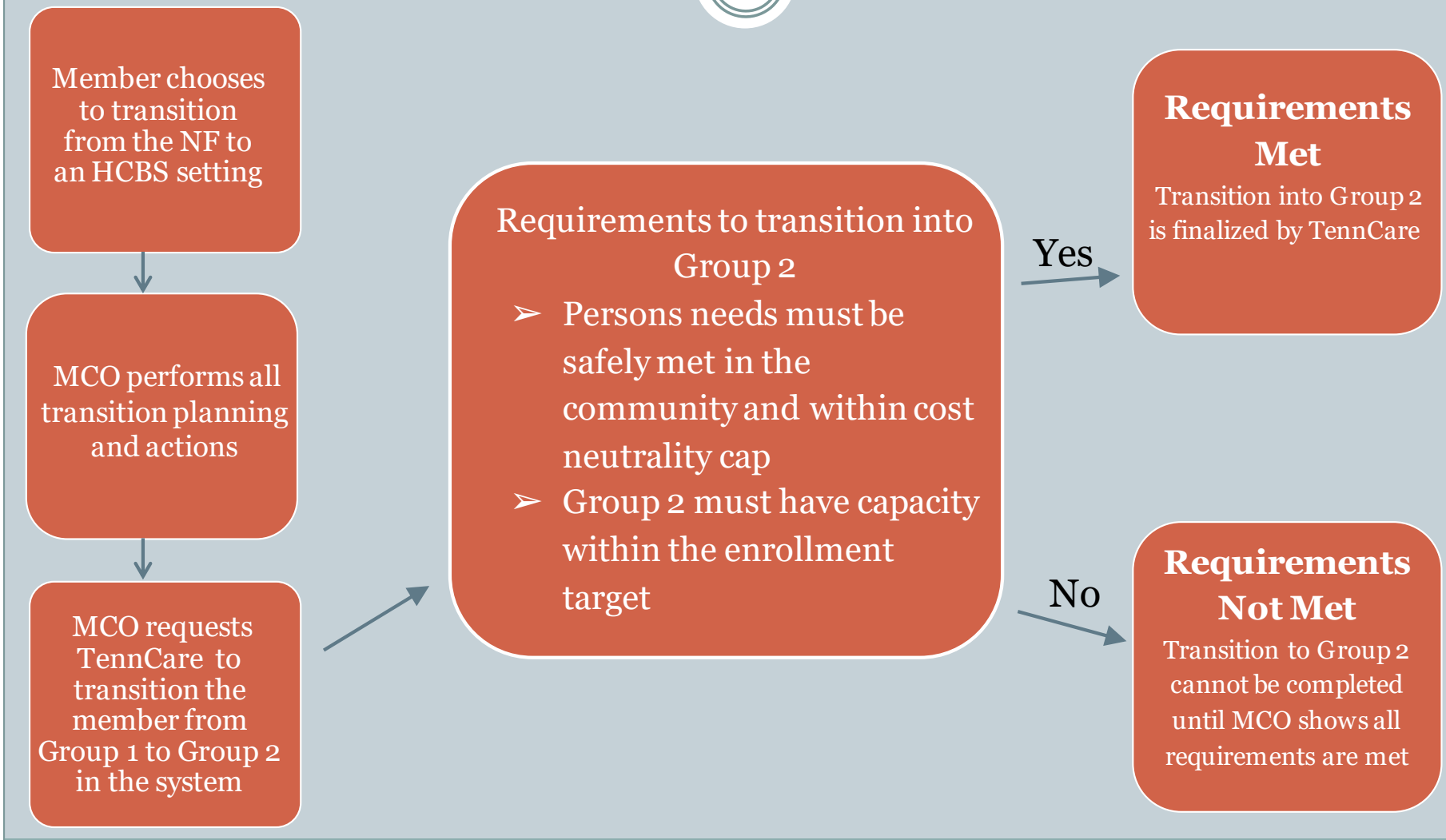
What if someone transitions from HCBS to NF long term?

When a person chooses to move from a HCBS setting to a NF on a long term basis, whether because a short term stay (STS) is not appropriate or the STS exceeds 90 days of Medicaid reimbursed NF care, **the MCO must transition the member from Group 2 or 3 to Group 1.**

Transitions

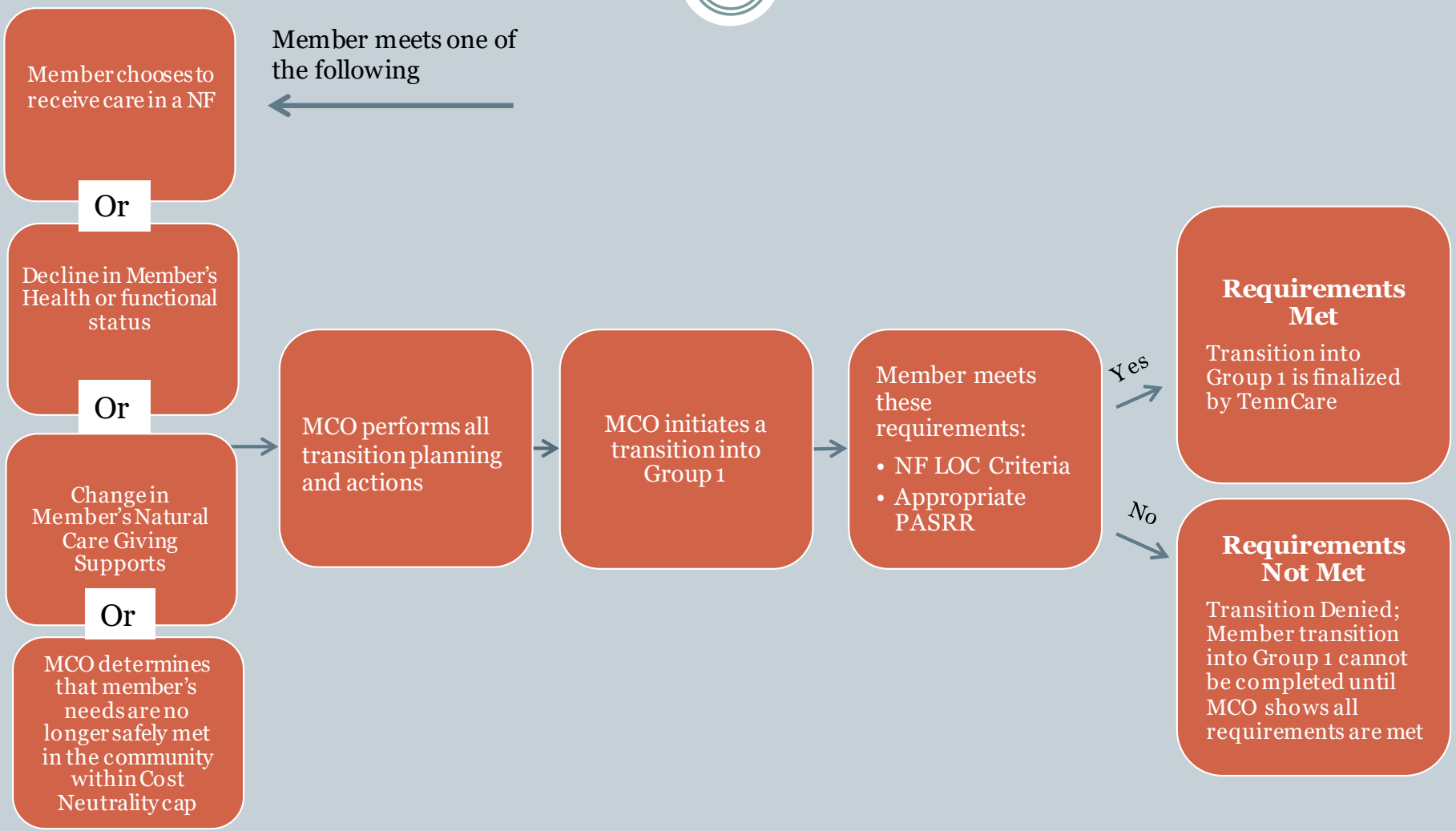
Transitioning between CHOICES groups

Transitioning from Group 1 to Group 2



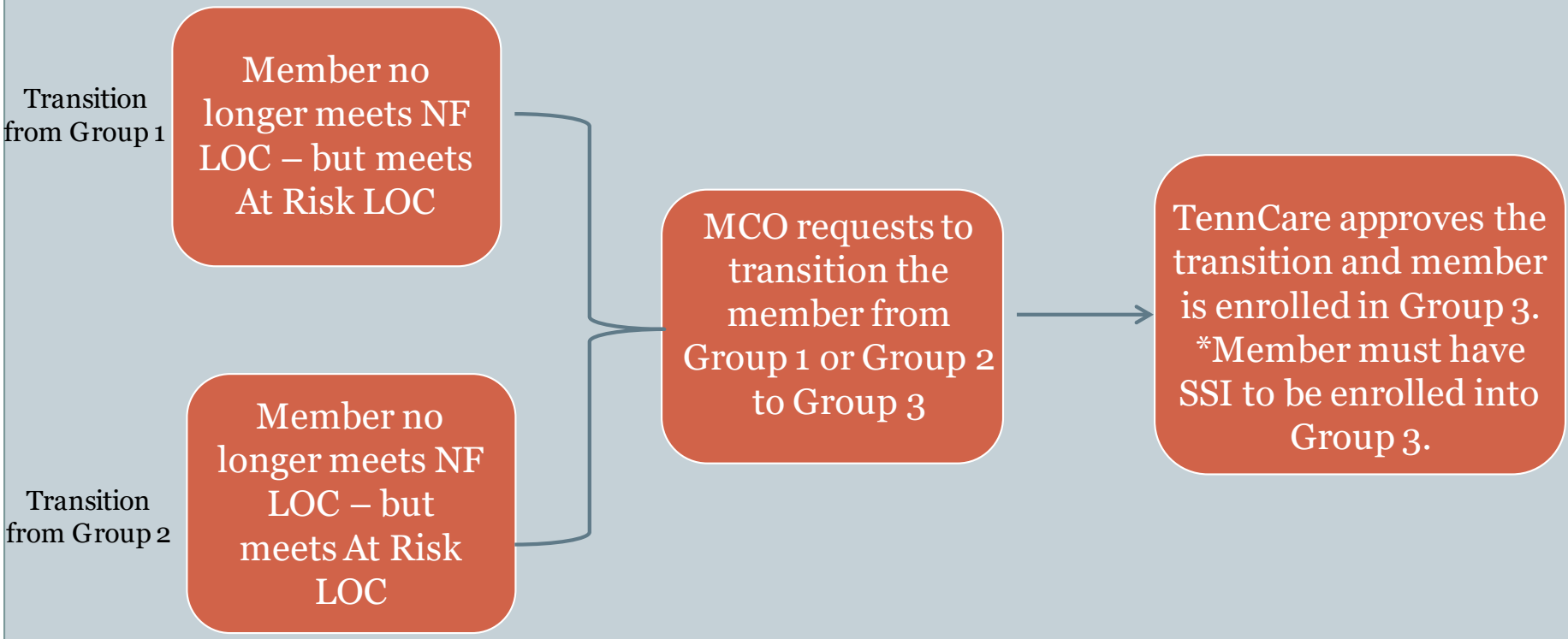
When members move from Group 1 to Group 2, TennCare Member Services must recalculate the member's Patient Liability.

Transitioning from Group 2 to Group 1



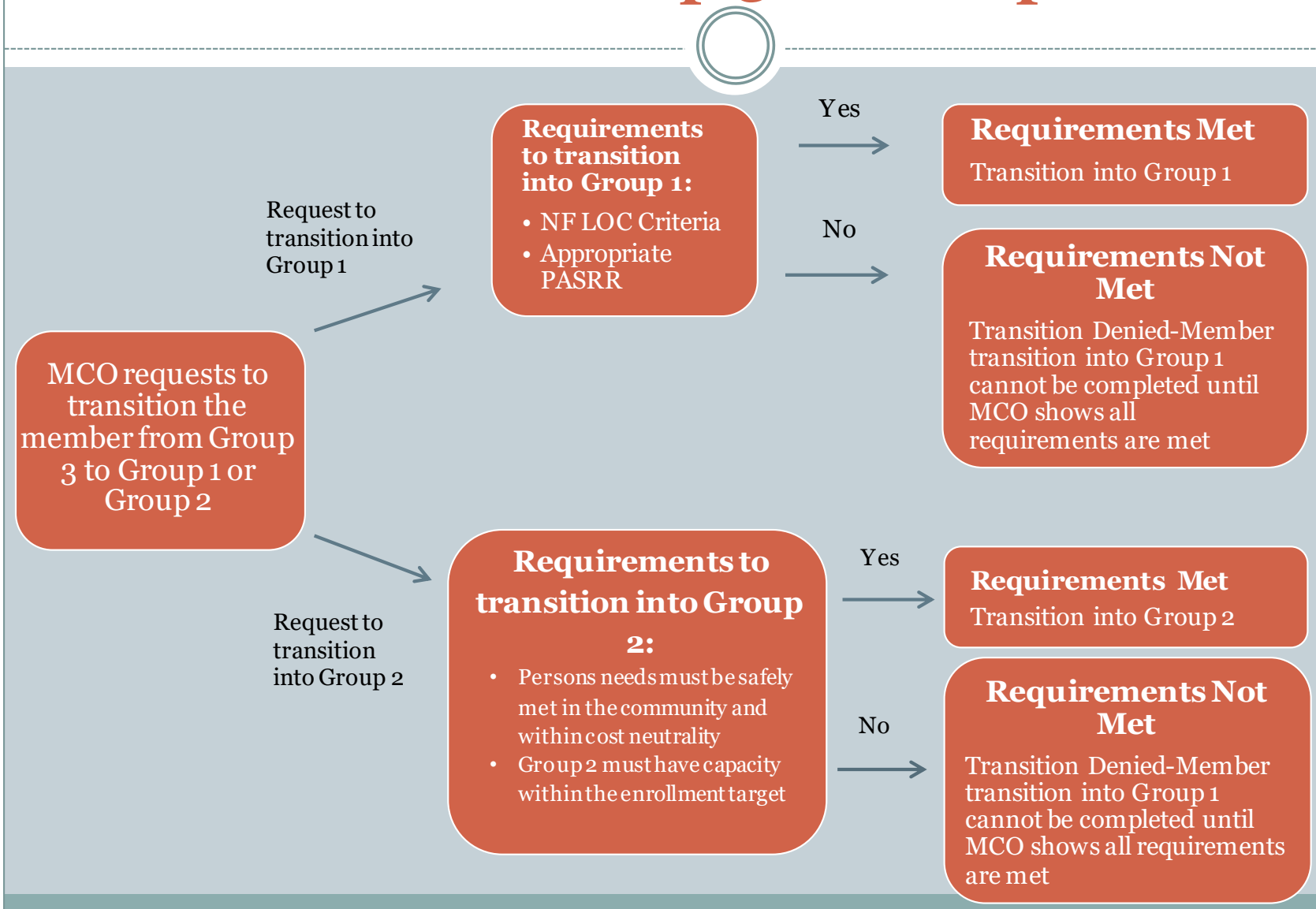
When members move from Group 2 to Group 1, TennCare Member Services must recalculate the member's Patient Liability.

Transition from Group 1 or Group 2 to Group 3



When a member transitions from CHOICES Group 1 to Group 3 TennCare Member Services must recalculate the Member's Patient Liability.

Transition from Group 3 to Group 1 or Group 2



*When a member transitions from Group 3 to Group 1, TennCare Member Services must recalculate the member's Patient Liability. *

Transitioning between PACE and CHOICES

1. Member voluntarily transitions from PACE to CHOICES or vice versa

2. Communication and coordination between MCO and PACE begins

3. "Transitioning FROM entity" immediately contacts "transitioning TO entity" to help plan transition

Coordinate care during process	Identify potential risks/barriers	Develop and implement strategies to eliminate barriers and minimize risks

4. MCO and PACE answer member's questions about transition process.

5. "Transitioning FROM entity" completes TennCare form and submits to TennCare CHOICES mailbox

6. When request is received, TennCare will review, confirm, and process the transition.

If criteria not met at any time, notification will be sent to PACE and the MCO

If the transition involves a move from NF to HCBS or vice versa, TennCare LTSS will work with TennCare Member Services to re calculate the member's patient liability obligation amount.

TPAES Transitions: When do I need a new PAE?

CHOICES								
Enrollment Prior 7/1/12			New PAE?		**Enrollment After 7/1/12**			**New PAE?**
CH1-g	to	CH2-g	**N**		CH1-r	to	CH2-r	**N**
CH2-g	to	CH1-r	**Y**		CH2-r	to	CH1-r	**N**
					CH3	to	CH1-r	**Y**
					CH3	to	CH2-r	**Y**
					CH1-r/CH2-r	To	CH3	**Y**

g = Grandfathered: If a **G** is present the member was approved based on the LOC in effect prior to 7/1/12 (Only applicable to CHOICES 1 & 2)

r = Regular: If an **R** is present the member was approved based on the LOC in effect on or after 7/1/12 (Only applicable to CHOICES 1 & 2)

Discharged from NF

Once a CHOICES member has discharged from the NF, he/she has voluntarily disenrolled from CHOICES Group 1 and must be newly enrolled into CHOICES Group 2 or 3. This is not a CHOICES transition.

If CHOICES HCBS is requested a new PAE shall be required for enrollment into CHOICES Group 2 or 3.

ICF/IID PAE

ICF/IID PAE

Nursing facility (NF) level of care (LOC) is one of two eligibility components (the other is financial eligibility) for Medicaid reimbursement of NF services. For Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) and Intellectual Disability (ID) Waiver Programs, the individual will require a diagnosis of ID with onset prior to age 18.

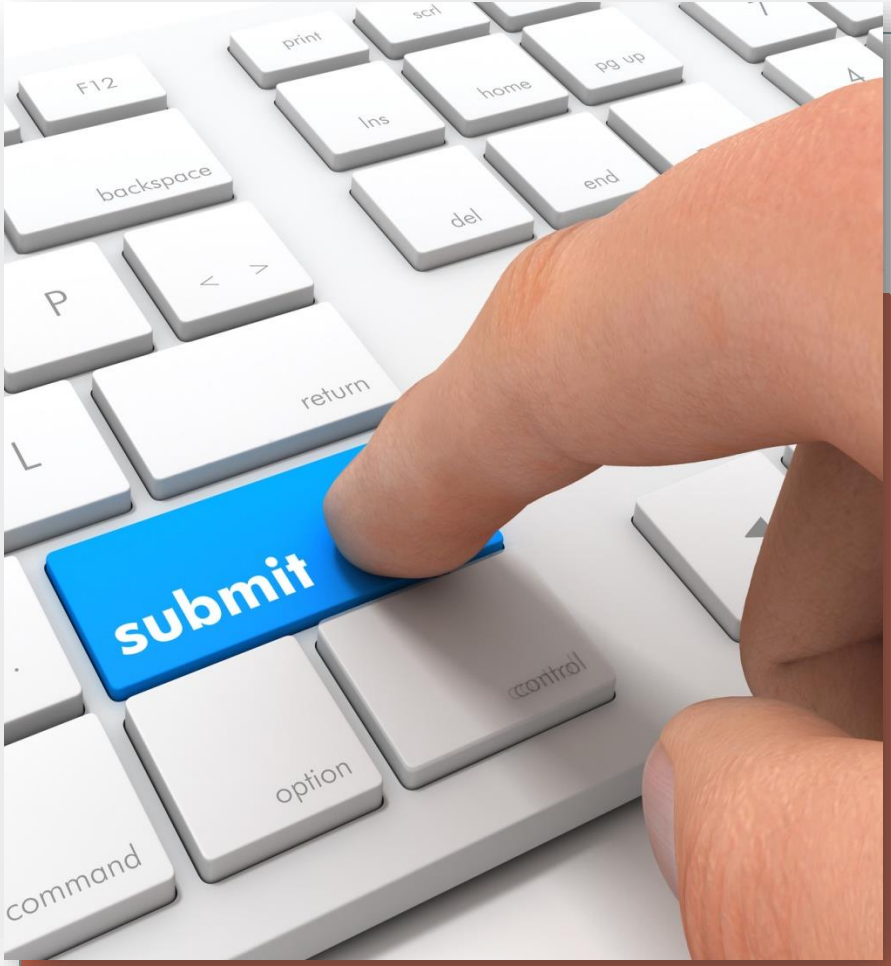
- Eligibility for LTSS ICF/IID requires the need for Specialized Services for Intellectual Disabilities or Related Conditions: The individual must require a program of specialized services for intellectual Disability Or developmental delay provided under the supervision of a qualified Intellectual Disability and developmental delay professional (QMRP). The individual must also have a significant deficit or impairment in adaptive functioning in one of the following areas:
- communication,
- comprehension,
- behavior,
- activities of daily living (e.g.,
- Toileting, bathing, eating, dressing/grooming, transfer, mobility).
- Medication Administration
- Vision
- Behaviors

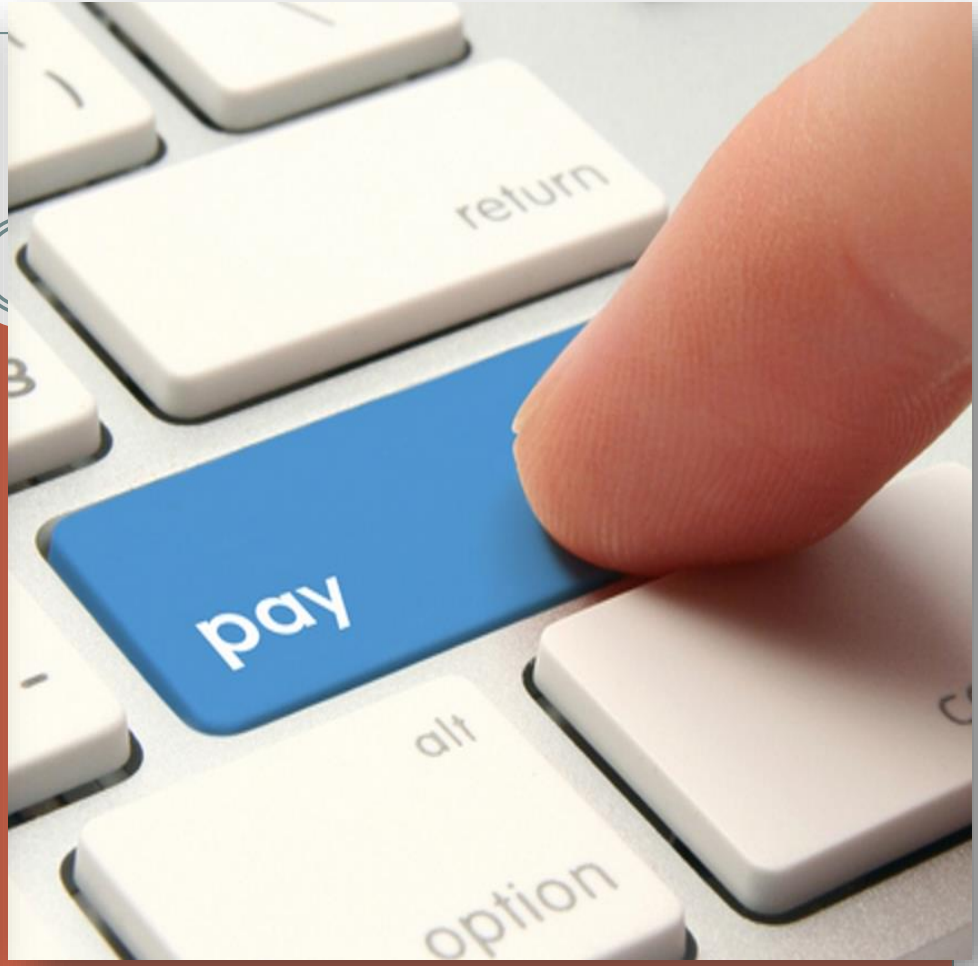
ICF/IID PAE

Cheat Sheets

Submitting a PAE-ICF/IID

***Currently in TPAES, ICF/IID is still referred to as ICF/MR*





Billing and Payment

Billing and Payment

- Nursing Facilities will bill for ALL TennCare non-ERC residents using revenue code 191.
- Nursing Facilities will bill for ERC using revenue code 192.

Billing and Payment

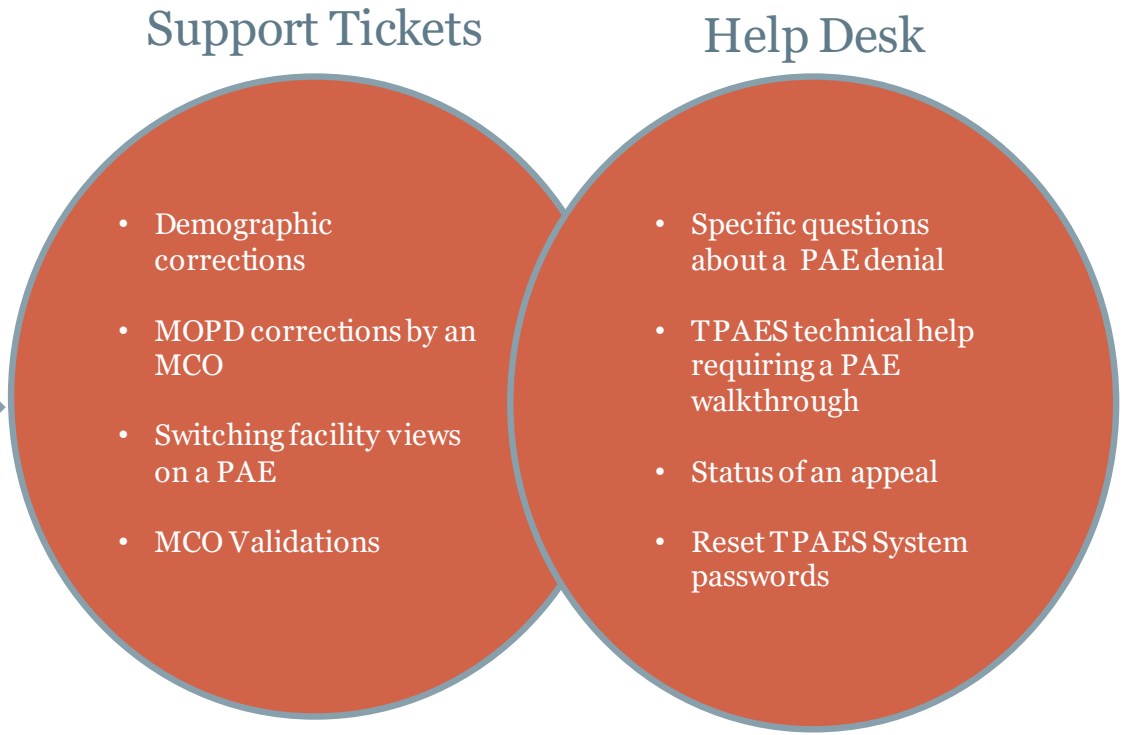
- There is not a separate level 1 or level 2 reimbursement or eligibility segment. There is only NF or Enhanced Respiratory Care.
- 1A segment in TNAnytime will reflect a person having NF eligibility
- 1B segment in TNAnytime will reflect a person having Enhanced Respiratory Care eligibility

Support Tickets

Please see this handy chart to clarify which corrections should be made through a support ticket

Keep in Mind....

The following list is not all inclusive for reaching out to LTSS via these routes. They are examples of how you should reach out to LTSS.



Support Tickets

Support tickets are a route to help correct certain issues within TPAES.

Support Tickets

Cheat Sheets

Support Tickets

Comprehensive Cheat Sheets

The following Cheat Sheets are comprehensive cheat sheets to help you walk through the process from start to finish.

- NF PAE Process
- HCBS PAE Process
- Eligibility and Enrollment
- ICF/IID PAE Process

- TPAES PAE Checklists:
- HCBS PAE-Checklist
- NF PAE-Checklist

Have Questions?

- **Email:** LTC.Operations@tn.gov
- **LTSS Help Desk:** 1-877-224-0219
- **Training Today Newsletter:** click **here**
- **LTSS Training Website:** click **here**
- **TennCare Connect:** 1-855-259-0701

Congratulations, You're Finished!

IF YOU ARE ATTEMPTING TO GAIN ACCESS TO TPAES PLEASE GO TO THE NEXT SLIDE.

WE APPRECIATE ANY FEEDBACK YOU MAY HAVE ABOUT THIS TRAINING AND ASK THAT YOU CLICK ON THE FOLLOWING LINK TO COMPLETE A SHORT TRAINING SURVEY:

HTTPS://SURVEY.ZOHOPUBLIC.COM/ZS/5JBOVG

TPAES Access

IN ORDER TO GAIN ACCESS TO TPAES YOU MUST COMPLETE THIS TRAINING. IF YOU HAVE COMPLETED THE TRAINING PLEASE CLICK THE LINK BELOW TO ACCESS THE CERTIFICATE OF COMPLETION. BY COMPLETING THIS CERTIFICATE YOU ATTEST THAT YOU HAVE COMPLETED THIS TRAINING IN ITS ENTIRETY AS REQUIRED.

FOR MORE INFORMATION ABOUT TPAES ACCESS PLEASE REVIEW THE SLIDES TITLED 'TPAES ACCESS' AND 'HOW DO I GET ACCESS TO TPAES?'

HTTPS://WWW.TN.GOV/TENNCARE/LONG-TERM-SERVICES-SUPPORTS/LTSS-CERTIFICATE-OF-COMPLETION.HTML

TN Division of TennCare